Government Business Division
Policies and Procedures

Section (Primary Department) **Utilization Management**		**SUBJECT (Document Title)** **Standing Referral to a Specialist - CA**	
Effective Date 05/27/1999	**Date of Last Review** 02/08/2024	**Date of Last Revision** 03/30/2023	**Dept. Approval Date** 02/08/2024
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Medicaid is committed to providing continuity, coordination, and quality of health care services for its members. The Primary Care Provider (PCP) is the principal coordinator of care when members require medical services from other health care service providers such as specialists. Anthem Medicaid expects the PCP to send and receive formal written communication describing the care rendered to members who have been referred for specialty care.

Anthem provides standing referrals to specialists for members with a “special condition”, who are determined to need a course of treatment or regular care monitoring. Specialists may also be assigned as PCPs on a case-by-case basis, according to the member’s diagnosis and health care needs. Treatment provided by the specialist must be appropriate for the member’s condition and identified needs. In this capacity the specialist may treat, authorize referrals, procedures, tests and other medical services for the member. Providing a standing referral to a specialist should reasonably enhance the clinical benefit to the member. The expectation is that referrals will be made to in network specialists when available. In “special circumstances”, consideration will be made for out of network providers. Both in network and out of network providers are held to time and distance standards when possible.

Ensure members with chronic, life threatening, degenerative, or disabling conditions have the right to obtain standing referral to specialists, this should include for specialty mental health and SUDs as defined in 438.900.

Anthem Medicaid allows women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services. This is in addition to the member’s designated source of primary care if that source is not a woman’s health specialist. Members may self-refer to obstetrical/gynecological (OB/GYN) network physicians.

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DEFINITIONS:

"Special Circumstances" (1) Continuity of care for patients with pre-established relationship with a provider or (2) lack of providers available in the area where the patients resides or (3) access to centers of excellence for specialized care.

"Special Condition" is a (1) life threatening, degenerative, or disabling condition or (2) requiring specialized medical care over a prolonged period of time.

PROCEDURE:

I. The PCP determines when a member needs specialty care.

A. In-Network

1. The PCP refers a member to the in-network specialist without prior authorization from Anthem Medicaid.

2. Self- referred OB/GYN visits does not require a referral from the PCP.

B. Out of Network

1. The PCP calls/faxes the Utilization Management (UM) Department to request initial pre-service authorization for out of network specialists

2. Requests for referrals to out of network specialists may be authorized based on medical necessity and availability of in network specialists.

3. The determination shall be made within three (3) business days of receipt of request and other items of information necessary to make the determination are provided.

4. Once a determination is made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any, is submitted to the physician reviewer. Services shall be authorized as medically necessary for proposed treatment, utilizing established criteria and consistent with benefit coverage.

5. If standing referrals are made to providers who are not contracted with the Plan Partner network, the Plan Partner shall make arrangements with that provider

for timely and appropriate reimbursement and for coordination of the member's care.

II. Subsequent Specialist Care:

A. In-Network

1. All subsequent visits to the specialist do not require pre-service authorization as long as the specialist deems the visits medically necessary and the member retains eligibility with Anthem Medicaid.

B. Out of Network

1. All subsequent visits to the specialist and/or unusual specialty services require pre-service authorization as long as the specialist deems the visits medically necessary and the member retains eligibility with Anthem Medicaid. Determinations will be made within 3 business days.

III. Members with a "Special Condition" or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative or disabling may select the specialist as his/her PCP. (ex: AIDS).

IV. Out-of-network specialty referrals are tracked in the electronic Anthem Care Management Platform (ACMP). An Authorization and a Claims data report is published on a quarterly basis which may be reconciled to determine whether or not the member utilized the authorization.

REFERENCES:

- CA Health and Safety Code 1374.16, 1367.69
- Central Valley/Bay Area, Sacramento, Tulare, Tri-County (Kings, Fresno, Madera) and LA Care Contracts, Exhibit A, Attachment 9
- Medi-Cal Evidence of Coverage 2023
- Provider Operations Manual, Last updated January 2023
- Welfare and Institutions Code 14450.5

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RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management

Secondary Department(s):
None

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
02/08/2024	• Annual Review—no changes
03/30/2023	• Off-Cycle Review • Updated Policy section
01/25/2023	• Annual Review • Updated Policy and References sections
02/03/2022	• Annual Review, updated references and placed in alphabetical order
01/27/2021	• Annual Review, no changes
01/29/2020	• Annual Review, updated references
01/30/2019	• Annual Review, changed WMDS to ACMP, updated references
01/30/2018	• Annual Review, updated references
01/30/2017	• Annual review. Updated OON determination from 5 business days to 3 business days
05/30/2016	• Annual Review, no changes
06/30/2015	• Updated references • Removed Time of auth under procedure
09/04/2014	• Removed Healthy Families • Changed 3 business days to 5 business day for TAT of request • Government Business Division
09/24/2013	• Deleted I.B.6 &7 in error during last review. Added verbiage back in concerning tracking and monitoring OON referrals in WMDS as it was determined that reports are generated on a quarterly basis.
06/19/2013	• Removed PURPOSE section from policy as per current template

Review Date	Changes
	• Added language about providing a direct referral in the POLICY section as well as language about direct access to an OB/GYN • Deleted I.B.6 &7 as this process is no longer being followed and does not appear to be a regulatory requirement. • Updated references
07/23/2012	• Changed references from Anthem Blue Cross and Blue Shield State Sponsored Business to Anthem Medicaid • Corrected decision timeframe from 5 business days to 3 business days following receipt of the appropriate medical records per LA Care audit finding • Corrected formatting • Expanded abbreviations • Added revision history to policy
05/27/1999	• Policy created