	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 404-1303</p>	<p>Lead Department: Utilization Management</p>
<p>Title: Referral Consultation Request Process</p>	
<p>Original Date: 02/01/1996</p>	<p>Date Published: 12/30/2024</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

Purpose:

To describe Central California Alliance for Health's (the Alliance's) Referral Consultation Request process.

Policy:

Members are referred by Primary Care Provider (PCP) or In-Network Specialist to a specialty physical health care provider within the Alliance Service Area or Local Out of Service Area.

Prior authorization is required for any service provided by a non-contracted, non-credentialed and/or out network provider. In the following instances a Medi-Cal member may access services from any provider, including providers not contracted with the Alliance without referral or authorization.


1. **Sensitive Services:** Pregnancy testing and counseling, birth control, human immunodeficiency virus infection (HIV)/acquired immunodeficiency syndrome (AIDS) testing, sexually transmitted infection (STI) testing and treatment, and termination of pregnancy. For a specific list of sensitive services please reference Alliance Policies 404-1309 - *Member Access to Self-Referred Services* and 404-1709 - *Provision of Family Planning Services to Members*. Members may access sensitive services from any Medi-Cal enrolled provider.
2. **Emergency Services:** Inpatient and Outpatient covered services that are furnished by a Provider that is qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. Members may receive emergency services from any provider, including providers not contracted with the Alliance and not enrolled in Medi-Cal.
3. **Gender Affirming Care (GAC):** PCP referral and prior authorization are not required for office visits related to Gender Dysphoria and/or Gender Affirming Care (GAC).

Definitions:

Alliance Service Area: The Alliance's Medi-Cal Service Area consists of Santa Cruz, Monterey, and Merced counties. The Alliance's Service Area for In-Home Supportive Services (IHSS) is Monterey County.

California Children's Services (CCS): CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through their Medical Therapy Unit (MTU).

Local Out of Service Area Provider: A specialist physician, hospital or allied provider based in an area adjacent to the Service Area, with whom the Alliance has contracted based on an existing referral pattern and claims payments, and the need for access to the provider's specialty type.

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Referral Provider: Any qualified physician who has executed an agreement with the Alliance to provide referral physician services, to whom a PCP may refer any member for consultation or treatment.

Referring Provider: PCP or Specialist that refers a member to Specialist Provider/s for services.


Whole Child Model (WCM): The purpose of the WCM program is to incorporate services covered by the CCS Program into Medi-Cal managed care for Medi-Cal-eligible CCS Program members. Managed care plans (MCPs) operating in WCM counties will integrate Medi-Cal managed care and CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

Procedures:

- I. **Referrals from Primary Care Provider (PCP) to Specialist Providers**
 - A. The PCP initiates the referral process to Specialist.
 - B. The authorizing (member linked) PCP submits the Referral Consultation Request required information. The required information to complete the request may include eligibility of the member and number of visits, services and/or period of service to be rendered and will vary according to the method of the submittal (Provider Portal vs. Referral Consultation Request Form).
 - C. The PCP sends the Referral Consultation Request to the Alliance via the Provider Portal or fax as noted in B. The PCP sends copy (electronically or by paper copy) to the Referral Physician or other provider with a request for a report of the service rendered by the other party.
 - D. The PCP tracks the request and the respective reports.
 - E. Upon completion of the initial examination of the member and subsequent authorized treatment, the Referral Provider shall:
 1. Advise the PCP of the patient's condition, proposed procedures and prognosis throughout the period of treatment; and
 2. Provide the PCP a written report and other oral reports as appropriate, regarding the diagnosis, other findings and prognosis within ten days following the patient contact.
 - F. If the service requires pre-authorization, the requesting provider must submit a request. Requests will be handled according to Alliance Policy 404-1201 - *Authorization Request Process*.
 - G. The referral physician or other provider retains a copy for their files. The Referral Consultation Request number should be indicated on the medical claim form submitted to the Alliance.
 - H. For the Medi-Cal line of business:
 1. For WCM CCS-eligible members, an authorization is required for all Specialist referrals.

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2. For all other members, no authorization is required for referrals to contracted providers within our service areas.
 - I. For Knox-Keene lines of business, authorization is required when referrals are made to non-contracted providers in our service areas. Referrals to non-contracted providers are authorized when there is a compelling medical reason that the services cannot be performed by contracted providers. The Alliance encourages specialty referrals and consultations. *Compelling medical reason* means only that the Alliance encourages referrals to contracted providers for Knox-Keene lines of business whenever possible. If, in these cases, medically necessary services are not readily available by contracted providers, there is no hesitation in referring to non-contracted providers.
 - J. For all lines of business, the Alliance reviews these referrals to monitor PCP case management activities and network adequacy for provision of specialty care. For all lines of business, referrals to Out-of-Network specialists (regardless of contract status) will require authorization. Please see Alliance Policy *404-1310 - Authorization Process for Referrals to Out of Network and Non-Contracted Specialty Providers* for more detail on referrals to Out-of-Network Specialists.
 - K. Referrals are time sensitive and unless otherwise specified, a referral will expire in 90 days; if so indicated on the referral, however, the authorization may be valid for periods of up to one year, at which time a new referral is required.
 - L. The Alliance ensures that determinations for standing and extended referrals are made on a timely basis as outlined in Alliance Policies *404-1306 - Extended and Standing Referral Authorizations* and *404-1201 - Authorization Request Process*.
 - M. Payment of claims for authorized services is subject to verification of the member's eligibility at the time services were rendered.
 - N. The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.
 - O. Services related to the members CCS condition, should be referred to a CCS paneled provider or specialist.
- II. Referrals from Specialist to Specialist**
- A. In cases where a specialist refers to different specialty, an authorization request form will be completed and submitted to the Alliance for review for out-of-network providers.
 - B. Requests will be handled according to Alliance Policy *404-1201 - Authorization Request Process*.
 - C. The required information to complete the request includes member information, servicing provider information, reason for referral, chief complaint and/or diagnosis, number of visits, services and/or period of service to be rendered.

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- D. Upon completion of the initial examination of the member and subsequent authorized treatment, the Referral Provider shall:
 - 1. Advise the referring provider and PCP of the patient's condition, proposed procedures and prognosis throughout the period of treatment; and
 - 2. Provide the referring provider and PCP a written report, and other oral reports as appropriate, regarding the diagnosis, other findings and prognosis within ten days following the patient contact.
- E. For all lines of business, the Alliance reviews these referrals to monitor PCP case management activities and network adequacy for provision of specialty care.
- F. Referrals are time sensitive and if so indicated will remain valid for periods of up to one year, at which time a new referral is required. Unless otherwise indicated, referrals expire in 90 days, but may be extended.
- G. Payment of claims for authorized services is subject to verification of the member's eligibility at the time services were rendered.
- H. The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.
- I. Services related to the members CCS condition should be referred to a CCS paneled provider or specialist.

III. Referrals from Emergency Department (ED) to Specialist

- A. In an effort to reduce delays for urgent follow-up care in specific time-sensitive clinical circumstances, the Alliance allows direct referral from the Emergency Department physician to the specialist. ED providers may refer directly to the following specialists for the referenced treatments. These do not require a Referral Form or any documentation for payment purposes:
 - 1. Orthopedic surgeons: for documented or suspected fracture, sprains, and strains
 - 2. General surgeons: For chronic cholecystitis
 - 3. Ophthalmologists: For emergency retinal detachment; corneal abrasions, burns and retained foreign bodies; acute ocular infections; and glaucoma emergencies
 - 4. Pain management: For acute or acute on chronic lumbar and/or cervical radiculopathy
- B. In the clinical situations described above, prior authorization is not required for referral to the specialist.

IV. Referrals from Indian Health Services (IHS) facility to Specialist

- A. Effective 1/1/2024, IHS providers, whether contracted or Out-of-Network, may provide referrals directly to in-network providers without requiring referral from a network PCP or prior authorization in accordance with 42 CFR section 438.14(b).ⁱ

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V. Emergency Service Referrals

- A. All members may self-refer to the Emergency Department (ED) for emergency services without authorization, based on the member's belief that they have an emergency.
- B. All members presenting at the ED will receive a Medical Screening Exam (MSE) by the ED.
- C. The Alliance pays for all MSEs. No authorization is required.
- D. The ED physician(s) uses the MSE to determine whether an emergency medical condition exists.
- E. The MSE will be performed in a non-discriminatory manner and regardless of the individual's ability to pay for medical care.

References:

Alliance Policies:

- 300-4080 - Open Access to Care
- 300-7030 - Reimbursement of Non-contracted Providers
- 300-2002 - Recruitment - Referral Physicians
- 404-1201 - Authorization Request Process
- 404-1306 - Extended and Standing Referral Authorizations
- 404-1309 - Member Access to Self-Referred Services
- 404-1310 - Authorization Process for Referrals to Out of Network and Non-Contracted Specialty Providers
- 404-1312 - Standing Referral to HIV/AIDS Specialists
- 404-1709 - Provision of Family Planning Services to Members

Impacted Departments:

- Community Care Coordination
- Claims
- Member Services
- Provider Services
- Quality Improvement & Population Health

Regulatory:

Legislative:

Contractual (Previous Contract):


- DHCS Medi-Cal Contract, Exhibit A, Attachment 9, Provision 5.C
- DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Provision D.4
- DHCS Medi-Cal Contract, Exhibit A, Attachment 18, Provision 10.d
- DHCS Medi-Cal Contract, Exhibit E, Attachment 3, Provision 5

Contractual (2024 Contract):

- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.8.F
- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.5.A.2
- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 3.2.3.G

DHCS All Plan Letter:

NCQA:

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Supersedes:

Other References:

DHCS AIR dated 01/06/2015

Strategic Plan 2022-2026 - Central California Alliance for Health:

PERSON-CENTERED DELIVERY SYSTEM TRANSFORMATION

Attachments:

Lines of Business This Policy Applies To

- ☐ DSNP
- ☒ Medi-Cal
- ☒ Alliance Care IHSS

LOB Effective Dates

- (01/01/2026 - present)
- (01/01/1996 - present)
- (07/01/2005 - present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
10/05/2021	10/05/2021	Tammy Brass, RN UM/CCM Manager	UMWG
02/13/2023	02/14/2023	Paige Harris, Regulatory Reporting Supervisor	UMWG
10/09/2023	10/09/2023	Danah Hernandez, UM Regulatory Reporting Supervisor	UMWG
02/23/2024	02/23/2024	Danah Hernandez, UM Regulatory Reporting Supervisor	UMWG
11/12/2024	11/12/2024	Tisa Llamas, RN Prior Authorization Supervisor	UMWG

ⁱ 2024 Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.8.F.