

Contra Costa Health Plan

Utilization Management

Title: Specialist Referrals

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Applies to:

Medi-Cal

BHC

Medicare

State Sponsored

Commercial

All N/A

Regulatory/Accreditation:

CMS:

Other Reg. References:

DMHC:

NCQA:

DHCS:

N/A

Units:

Administration

Business Services

Marketing

Provider Affairs

Advice Nurses

Care Management

Member Services

Qual Management

All Staff

Health Ed/Cultural Ling.

Planning, Survey, Reg Affairs

Auth/Utilization Management.

POLICY

Contra Costa Health Plan (CCHP) provides specialist services in circumstances when the medical needs of the member require expertise beyond that of the Primary Care Provider (PCP).

PROCEDURE

CCHP offers different types of insurance (e.g., Medi-Cal, Commercial A, Commercial A2, Commercial A2-IHSS, etc.) with different provider networks (e.g., CCRMC Network, CPN Network). Traditionally, this has caused confusion for providers in our provider network. Given these different networks affect member's eligibility for services with specialists, clarification is provided here.

- For Medi-Cal members in the CPN, their providers can refer a CPN or CCRMC specialist through this process if the specialist does not require a prior authorization as discussed below.
- For Medi-Cal members in the CCRMC Network, their providers can refer to a CCRMC or CPN specialist through this process if the specialist does not require a prior authorization as discussed below.
- For Commercial A/Commercial A2/Commercial A2-IHSS, whose network is only CCRMC, any referral to a specialist outside of CCRMC requires prior authorization.
- For Commercial B, their providers can refer to a CCRMC or CPN specialist through this process if the specialist does not require a prior authorization as discussed below.

A Health Plan PCP/other referring provider can directly make an initial specialist referral (excludes certain specialists, such as, pain management, neurosurgery, etc. as discussed below) for a member to a contracted, in-network specialist without a prior authorization from the Plan for an initial consultation and six additional

follow-up visits.

1. PCPs in the Regional Medical Center Network (RMCN) can make referrals electronically via ccLink.
2. PCPs in the Community Provider Network (CPN) can use the ccLink Provider Portal. For those providers not yet on the ccLink Provider Portal, they may continue to use the CCHP Specialist Referral Form until they receive Provider Portal Access.
3. All referrals for specialists (excluding procedures) are valid for a minimum of seven visits (one initial visit + six follow up visits) over the course of one year. The initial visit must be completed within 90 days of the initial referral date. Additional follow-up care after the first seven visits requires prior authorization. If anything in addition to the referral is listed on the consult, those additional codes may be subject to prior authorization, as illustrated below:
 - If all things listed in addition to the consult are on the no auth list or referral only list, then the referral may proceed with no prior authorization.
 - i. Example: The referral includes 1) a consult that requires PCP/other referral but no prior authorization and 2) a procedure CPT code that is on the no auth list or 2) a procedure CPT code that is on the referral only list (UM 15.003 and below). In this case, the consult and procedure may proceed with the provider referral without prior authorization.
 - If anything listed in addition to the consult requires prior authorization, then those codes are subject to prior authorization and may NOT proceed without prior authorization.
 - i. Example: The referral includes 1) a consult that requires PCP/other referral but no prior authorization and 2) a procedure CPT code that requires prior authorization. In this case, those additional CPT codes are subject to CCHP review and prior authorization before proceeding. For this same scenario, the referring provider can instead choose to submit two referrals, one for the consult and one for the procedure. If this is done, then the referral for the consult can proceed without prior authorization but the referral for the procedure would still be subject to CCHP review and prior authorization prior to proceeding.
4. If a procedure is listed on the referral and approved (either because it is on the no auth list or via prior authorization), it can be performed one time within 90 days of the initial referral date.
 - Any repeated procedure would need prior auth and medical justification.
5. After referring to a specialist, the PCP/referring provider is responsible to ensure that the specialist receives a copy of the referral and all pertinent clinical information.
6. After submission, the referring provider (PCP/other provider) must notify the specialist.
 - If PCP/referring provider (CPN) submitted through the ccLink Provider Portal or through ccLINK (CCRMC specialist) AND a specialist was specified.
 - i. No further notification is required as a notification will be sent to the referred to specialist.
 - If the PCP/referring provider (CPN) submitted through fax as they do not yet have access to the provider portal.
 - i. The PCP/referring provider must fax a copy of the referral the CPN or CCRMC specialist.
7. After referral, the PCP/referring provider is responsible to ensure all required documentation and clinical information is provided to the specialist.

After referral, the PCP/referring provider or the patient must schedule the appointment with the provider.

8. The consulting specialist is responsible for faxing all clinical documentation back to the referring provider. For CCRMC Providers, please send to medical records at Fax 925-370-5239. For CPN providers please check with the individual provider for the best way to communicate this information.

Referral Only List (from UM 15.003)

A PCP in the Community Provider Network (CPN) uses the ccLink Provider Portal or Health Plan Referral Form to directly initiate a new referral for a member for the services listed below to an in-network provider. Likewise, a PCP in the Regional Medical Center Network (RMCN) uses the ccLink electronic referral process to initiate a new referral for to an in-network provider for the following services:

SERVICES REQUIRING PCP/OTHER PROVIDER REFERRAL ONLY AND NO HEALTH PLAN PRIOR AUTHORIZATION – NO REFERRAL NEEDS TO BE SENT TO CCHP

These services require PCP/other provider referral only and no health plan prior authorization include (as long as the services are covered by the member's benefit plan, are medically necessary, and rendered by a contracted in network provider for the member):

- Computerized Tomography (CT) Scans (except for total body scans)
- Dexa Scan: (for members ≥ 65 y/o with no previous DEXA in the last 2 years) see referral form for further guidelines
- ECHO
- EEG
- EKG
- Labs (excludes genetic testing, which requires authorization)
- Mammograms (no more than one every 12 months)
- Magnetic Resonance Imaging (MRI) & Magnetic Resonance Angiography (MRA) (subject to change)
- OB ultrasound (limited to 2 OB ultrasounds; unlimited if requested by perinatologist)
- Pulmonary function tests
- Thyroid Scan
- X-Rays (non Mammograms – mammograms limited as above)
- PLEASE NOTE THAT Prior Authorization is required for other imaging, including, but not limited to, PET Scans and other ultrasounds
- Other services listed on the Interactive Health Plan No Authorization List that are not listed in the section requiring a copy of the referral be sent to CCHP.**

**Please note: The Interactive No Authorization Required list is subject to change at CCHP's discretion. It is the provider's responsibility to obtain any required authorization prior to rendering services.

The electronic No Authorization Required interactive list is located on our website at <https://cchealth.org/healthplan/providers>. This list can be searched by CPT code and should be checked periodically for updated versions. When the service is on the Interactive No Authorization Required List, a Prior Auth request is not required as long as the service is medically necessary and **covered under the member's benefit package, medically necessary, and rendered by a contracted in-network provider for**

that member.

SERVICES REQUIRING PCP/OTHER PROVIDER REFERRAL ONLY AND NO HEALTH PLAN PRIOR AUTHORIZATION – COPY OF REFERRAL NEEDS TO BE SENT TO CCHP

A referral to a CCHP contracted specialty care provider is initiated by a PCP or other provider electronically (CPN provider: ccLINK portal, CCRMC provider: ccLINK referral order).

For all referrals PCP or other provider must include all pertinent diagnostic and medical information with their request.

Services that require PCP/other provider referral only and no health plan prior authorization include (as long as the services are covered by the member's benefit and rendered by a contracted in network provider for the member) include:

1. Chemo and Radiation Therapy (for cancer related diagnosis) **except for intensity-modulated radiation (IMRT)**
2. Audiology (1+6)
3. Chiropractor (1+6) (Medi-Cal)
4. Community Health Worker: Up to 2 hours a day for up to a total of 6 hours does not require prior authorization. Any amount beyond 2 hours a day must be reviewed via prior authorization and may be authorized if medically necessary. After 6 total hours a year, a treatment plan is required and CCHP will conduct retrospective prior authorization review to ensure that the hours provided are medically necessary and within quantity limits based on the goals provided in the plan of care. Dietician Consultation (1+6)
5. In-Home Hospice Services
6. Physical Therapy, Speech Therapy, and Occupational Therapy (1+6)
7. Initial specialist consult and six follow-up visits in network are allowed without prior authorization. Exceptions are listed below:
 - **Prior authorization is required for:**
 - **Out of network referrals**
 - **Tertiary care centers: including, but not limited to: UCSF, Stanford, Lucille Packard, or other noncontracted facilities**
 - **Subspecialty, and panel evaluations: including, but not limited to: pain management, bariatric surgery evaluation (including mental health evaluation for bariatric surgery which should be submitted at the same time as the bariatric surgery evaluation request), neurosurgery referrals, transgender consults and referrals, organ transplant evaluation**
8. Minor Surgery: Punch Biopsy, Nail Removal, TAB, D & C, Foreign Body Removal, ORIF of finger, Vitrectomy, Porta Cath Placement, Hardware Removal, FNA, Breast Biopsy, Hemorrhoid Sclerosing, and Malignant Lesion Treatment (one time).
9. Ophthalmology (can be referred by a contracted Optometrist)
10. Procedures (one procedure per referral): Sigmoidoscopy, Bronchoscopy, Cystoscopy, Colposcopy, Colonoscopy, Endoscopy, ERCP, and Mediastinoscopy
11. Rehabilitation Services (outpatient): physical, occupational, or speech therapy.
12. Tuberculosis treatment (coordinated by the Local Health Department and in compliance with the recommended guidelines by American Thoracic Society and the Centers for Disease Control and Prevention, which includes screening, diagnosis, inpatient and outpatient medical services related to the diagnosis and treatment, and follow-up)

For the below specialty services, members can self-refer to a contracted, in-network, Health Plan specialist provider as long as coverage is included in their benefit package (refer to the listed policy for other considerations and details):

1. Outpatient OB/GYN visits
 - UM15.003-Policy for Prior Authorization
2. Sensitive services, such as family planning, abortions, STD & HIV testing and counseling
 - UM15.003-Policy for Prior Authorization
 - UM15.032-Direct Access to Obstetricians/Gynecologists
3. Outpatient psychotherapy services
 - #BH18.001-Access to Mental Health Services

Non-network, Non-contracted and Tertiary Care Specialty Services

Non-emergent out-of-network, out-of-plan, tertiary care center, or seldom used/unusual specialty service referrals require prior authorization by CCHP. The request is reviewed by the UM department to determine medical necessity and availability of services within the Health Plan provider network or with a non-contracted preferred provider. Services that are seldom used or unusual may require internet literature research or an external medical review to evaluate the latest evidence-based clinical practice standards prior to making a determination on the request. Refer to policy UM15.010- New Technology for details.

Referrals to and arrangements with a tertiary care center may be necessary and requires prior authorization to accommodate the unusual medical need of the member. An approval must be obtained from the Authorization Unit prior to rendering non-emergent services.

The Chief Medical Officer or designee reviews all out-of-network, out-of-plan or unusual specialty referrals not meeting criteria to:

1. Assess medical appropriateness.
2. If necessary, consult with specialist to determine medical justification of referral.
3. Identify potential quality issues for referral to appropriate Quality Management staff.
4. Identify potential fraudulent or abusive practices.
5. Support and maintenance of peer review, and
6. Provide a mechanism which enable members to explore other treatment options.

If a specialty service is authorized, the Authorization Unit will issue an approval letter to the member and the referred to provider. The letter indicates the name of the specialist and their contact information. For detailed information, refer to UM 15.015a-Timeliness of the Utilization Review Decision and Communication. If a member is referred to a specialist or tertiary care center and s/he is unable to navigate through the provider or institution's healthcare system, staff is available to assist the member with making arrangements.

Out of Network Care Coordination

Upon approval of care to a noncontracted provider, a written approval notice is issued to the member and copied to the referring provider and referred to provider. The notice includes PROVIDER instructions on where to submit consult, procedure and test reports. The referring provider, as appropriate will coordinate care with the referred to provider. When necessary, the member may be referred to Case Management for care coordination activities.