Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management**		**SUBJECT (Document Title)** **Specialty Referral**	
Effective Date 04/01/2003	**Date of Last Review** 08/25/2022	**Date of Last Revision** ~~08/25/2022~~09/29/2022	**Dept. Approval Date** ~~08/25/2022~~09/29/2022
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 – Empire	☒ Virginia
	☐ District of Columbia	☒ Maryland	☒ New York (WNY)	☒ Washington
	☒ Florida	☒ Minnesota	☒ North Carolina	☒ Wisconsin
	☒ Georgia	☒ Missouri	☒ South Carolina	☐ West Virginia
	☒ Indiana	☐ Nebraska		

POLICY:

To ensure all members who require specialist care receive access and follow-up care as deemed medically necessary and in compliance with state/federal requirements.

DEFINITIONS:

OIG: Office of Inspector General

SAM: System for Award Management is the Official U.S. Government system that consolidated the capabilities of CCR/FedReg, ORCA, and EPLS.

Specialty Care: Any service provided that is not provided by a Primary Care Provider (PCP).

PROCEDURE:

1) Members are encouraged to coordinate all specialty services/care with their PCP.
   a) PCP referrals are not required to see participating specialty providers, and
   b) Members (including but not limited to members with special health care needs), are allowed direct access (self-referral) to a specialty provider, dependent on the member's covered benefits.

2) If there is no specialty provider within the network that has the appropriate training or expertise to meet the member's particular health needs, or the specialty provider is outside of the access standard for the member, Health Care Management (HCM) coordinates with Provider Relations to locate an appropriate out-of-network provider for the member. A single case agreement is executed with the out-of-network provider for payment methodology as defined in the applicable Federal/State contracts or regulations. Additionally, Provider Relations is notified to work toward contracting a network agreement for the provider, or for additional providers within the same specialty.

3) PCP consults the provider manual, provider portal, or quick reference card, whichever is used by the affected health plan, to determine which services/care requires notification or precertification.
   a) Upon determining that the specialty service/care is a service that the member can access without precertification or notification to the health plan, the PCP documents the member's health care need(s) and his/her request for the consultation findings.
      i) If the PCP learns that the member received services via direct access/self-referral from a specialty provider, the PCP requests the rendering specialty provider send a note of his/her findings in order that he/she is aware of any treatment the member received, and to ensure the treatment is compatible with care that the PCP is rendering.
      ii) If the PCP is concerned about the compatibility of the care rendered by the specialty provider with the care he/she is rendering to the member, the PCP contacts the specialty provider and discusses the treatment plan.

4) If this is an OUT OF NETWORK (OON)/**NON PARTICIPATING** Provider, all of the following must be checked and documented in the note:
   a) **SAM** (formerly EPLS) – https://www.sam.gov/content/home
   b) **OIG** - http://exclusions.oig.hhs.gov/
   c) **Medicare Opt Out Site** – https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z**Medicare Precluded Provider List** - https://applications.antheminc.com/sites/imo/medicaidandchipmanagedcarefinalrulemarketimplementation/ProviderPreclusion/Provider%20Preclusion%20List/Forms/AllItems.aspx
   d) Where applicable, state provider termination and exclusion lists.
      i) Appropriate national databases to determine if the OON/non-par ordering and servicing provider(s) are excluded or have any sanctions on their license are checked. For Medicare, in addition to the exclusion/sanction checks, the appropriate database is reviewed to determine if the OON/non-par ordering or servicing provider(s) are on Medicare's Preclusion list; also, the appropriate database is checked to see if the servicing provider has opted out of Medicare (for Medicare Advantage Plans).

   If an exclusion/sanction exists for the ordering or servicing provider, or the ordering/servicing provider are precluded from Medicare, or the servicing provider has opted out of Medicare, the provider **cannot** be authorized for services. An alternate provider who is **not** excluded, precluded or opted out must be located.

REFERENCES:

- Florida AHCA SMMC Contract No. FP068

- Florida Healthy Kids Contract:2020-03 Medical Services and Coverage
- Iowa Health Link Contract 11.2.5.2; 3.3 and Attachment B
- Louisiana Medicaid Managed Care Organization Contract
- Louisiana Medicaid Managed Care Organization Manual
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- Nevada RFP40DHHS-S1457 7.6.3.9.3, 7.6.3.9.4
- Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement
- Texas Administrative Code (TAC) 1 TAC §353.4; 28 TAC §11.506 and §11.900
- Texas Uniform Managed Care Contract (UMCC) sections 8.1.3; 8.1.3.1; 8.1.4.2; 8.1.12.2
- Washington FCS TPA K2240, K4167 Amendment-13

Related Policies and Procedures:
Out of Network Authorization Process
Pre-Certification of Requested Services - Core Process

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management

Secondary Department(s): Provider Services Organization - National Provider Relations

EXCEPTIONS:

Medicare:
Out of network (OON) providers are reimbursed at the Medicare Allowable Rate (Medicare Fee Schedule). Since OON Medicare providers are **required** to accept Medicare Fee Schedule rates for reimbursement, single case agreements are **not** offered for rate negotiation.

Medicare Advantage Organizations (MAO's) are prohibited from paying providers that have chosen to 'Opt Out' of Medicare with the exception for emergency or urgently needed services. In addition, MAO's cannot contract with any provider or entity (ordering or servicing) on an Exclusion List, i.e.: sanctioned providers, or Medicare Preclusion list with the exception for emergency services. If a Medicare member refuses redirection to an alternate non excluded, precluded, opt out provider and does not want to withdraw the request, the pre-service request may need to be administratively denied.

Arkansas:
For enrollees with special healthcare needs determined through an assessment to need a course of treatment or regular care monitoring, each Provider-Led Arkansas Shared Savings Entity (PASSE) must have a mechanism in place to allow enrollees to directly access a

specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

Florida Medicare, Medicaid, Florida Healthy Kids:
PCP referrals are required to see participating specialty providers, and members are not allowed direct access (self-referral) to a specialty provider without a PCP or specialist referral.

AHCA Contract No. FP068 Attachment II, Exhibit II-A, Section VI.E.9.a.(3)
The Plan assures direct access to specialists for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs

AHCA Contract No. FP068 Attachment II, Exhibit II-A, Section VIII.A.4.a(2)
Female enrollees have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist.

AHCA Contract No. FP068 Attachment II, Exhibit II-A, Section VIII.A.8.

Timely Access Standards
(1) Appointments for urgent medical or behavioral health care services shall be provided:
a) Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.
b) Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization.

Florida Healthy Kids FHK 2020-03 Medical Services and Coverage Simply Contract Section 18-2-3-3
The Plan has processes in place to assess enrollees and provide those determined to have special health care needs with direct access to a specialist in a manner that is appropriate for the enrollee’s condition and identified needs.

Georgia:
This policy is also applicable to Georgia Families 360.

Iowa:
Health Plan shall facilitate provider requests for authorization for primary and preventive care services and shall assist the provider in providing appropriate referrals for specialty services by locating resources for appropriate referral. The Health Plan shall not require a PCP referral (if applicable) for members to access a behavioral health provider. Pursuant to the requirements

in Section 3.3 regarding transition of new members, the Contractor shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements.

The Health Plan shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of members are met within the Contractor's provider network. The Health Plan shall also have a system to refer members to, and pay for, non-network providers when medically necessary. The Health Plan shall also pay for non-network providers when a member has medical needs that would be adversely affected by a change in service providers. All non-network providers referred to and reimbursed shall have the necessary qualifications or certifications to provide the medically necessary service. At minimum, the Health Plan shall have provider agreements with providers practicing the following specialties: (i) allergy; (ii) cardiology; (iii) dermatology; (iv) endocrinology; (v) gastroenterology; (vi) general surgery; (vii) neonatology; (viii) nephrology; (ix) neurology; (x) neurosurgery; (xi) obstetrics and gynecology; (xii) occupational therapy; (xiii) oncology/hematology; (xiv) ophthalmology; (xv) orthopedics; (xvi) otolaryngology; (xvii) pathology; (xviii) physical therapy; (xix) pulmonology; (xx) psychiatry; (xxi) radiology; (xxii) reconstructive surgery; (xxiii) rheumatology; (xxiv) speech therapy; (xxv) urology; and (xxvi) pediatric specialties.

Kentucky:
The health plan shall monitor PCP's actions to ensure he/she complies with the following:

- Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within network;
- Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;

The health plan shall assure that all covered services are accessible to Members, including Specialty care in which referral appointments to specialists shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care; except for Behavioral Health Services for which services may not exceed seven (7) days post discharge from an acute Psychiatric Hospital.

The health plan shall have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical and subspecialty cases.

Any provider participating or applying to participate in the Kentucky Medicaid program must search the List of Excluded Individuals and Entities, the System for Award Management, and The Kentucky Medicaid Provider Termination and Exclusion list on a monthly basis to determine if any existing employee or contractor has been terminated or excluded from

participation in the Kentucky Medicaid program or has been nationally excluded from Medicare or Medicaid. Also, any provider participating or applying to participate in the Kentucky Medicaid program must search all lists prior to hiring staff to ensure that any potential employee or contractor has not been terminated and/or excluded from participating in the Medicare or Medicaid program.

Louisiana:

Refer to *Standing Referral – LA, Utilization Management – LA* and *Managed Care Organization (MCO) Manual – LA* policies.

~~Healthy Blue shall have a referral system for members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. Healthy Blue provides the coordination necessary for referral of members to specialty providers. Healthy Blue shall assist the provider or member in determining the need for services outside Healthy Blue's network and refer the member to the appropriate service provider. The referral system includes processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (e.g., medications prescribed, treatment received, recommendations for care), and follow-up are included in the PCP's member medical record. Information for accessing referral services is outlined in provider and member materials.~~

~~Healthy Blue shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the Contract is signed, and prior to any revision. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements:~~

- ~~When a referral from the member's PCP is and is not required;~~
- ~~Process for member referral to an out-of-network provider when there is no provider within the provider network who has the appropriate training or expertise to meet the particular health needs of the member;~~
- ~~Process for providing a standing referral when a member with a condition requires on-going care from a specialist;~~
- ~~Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;~~
- ~~Process for member referral for case management;~~
- ~~Process for member referral for chronic care management;~~
- ~~Policy that prohibits providers form making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship;~~
- ~~Process to ensure monitoring and documentation of specialty health care services and follow-up are included in the PCP's member medical record;~~

- There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider;
- Process for referral of members for Medicaid State Plan services that are excluded from Healthy Blue's core benefits and services and that will continue to be provided through fee-for-service Medicaid; and
- Healthy Blue shall develop electronic, web-based referral processes and systems.

Healthy Blue does not require referrals to in-network specialists. When there is no provider within the network who has the appropriate training or expertise to meet the particular health need of the member, Healthy Blue assists with finding an appropriate out-of-network provider. Prior authorization is required for all non-emergent out-of-network specialists (refer to *Out-of-Area, Out-of-Network Care – LA*), unless specified by exception (see exceptions listed below). Authorized referrals are documented in the clinical management system. When appropriate, members are referred for case management or chronic care management.

A standing referral may be provided when a member with a condition requires on-going care from a specialist (refer to *Standing Referral – LA*), this includes members with a life-threatening condition or disease who require specialized medical care over a prolonged period of time.

Referrals and documentation of specialty healthcare services are monitored and follow-up included in the PCP's member medical record. There must be written evidence of the communication of the patient results/information to the referring physician by the specialty healthcare provider or continued communication of patient information between the specialty healthcare provider and the PCP.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

Members are informed about how to access excluded services, and may be referred for State Plan services that are provided through fee-for-service Medicaid and excluded from MCO coverage. Healthy Blue provides all required referrals and assists in the coordination of scheduling such services for members (refer to *Non-Covered and Cost-Effective Alternative Services – LA* for additional information regarding excluded, non-covered, and in lieu of services).

If Healthy Blue elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, Healthy Blue must

~~furnish information about the services that it does not cover, in accordance with §1932(b)(3)(B)(ii) of the Social Security Act, 42 CFR §438.102(b)(1), and the Contract. For counseling or referral services that are not covered because of moral or religious objections, Healthy Blue shall direct the member to contact the enrollment broker for information on how or where to obtain the services. Healthy Blue shall not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources.~~

~~With respect to *Chisholm v. Gee*, Healthy Blue must maintain an outreach and referral system to direct Chisholm Class member with an Autism Spectrum Disorder (ASD) diagnosis to qualified healthcare professions, who can provide Comprehensive Diagnostic Evaluations (CDEs) required to establish medical necessity for Applied Behavioral Analysis (ABA) services.~~

~~Exceptions to referral and authorization requirements:~~

- ~~Healthy Blue shall not require service authorization for emergency services or post-stabilization services as described in the Contract, whether provided by an in-network or out-of-network provider.~~
- ~~Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.~~
- ~~Healthy Blue shall not require service authorization or referral for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening services.~~
- ~~Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the health plan, regardless of whether such services are provided by an in-network or out-of-network provider, however, prior authorization of services may be required beyond thirty (30) calendar days.~~
- ~~Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first thirty (30) days of a newly enrolled member's linkage to the plan.~~
- ~~Healthy Blue shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the Louisiana Health Plan for routine and preventive women's healthcare services and prenatal care.~~
- ~~Healthy Blue shall not require a PCP referral for in-network eye care and vision services.~~
- ~~Healthy Blue may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.~~
- ~~Healthy Blue may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours is denied.~~
- ~~Healthy Blue may require notification by the provider of obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical~~

~~admission exceeding ninety-six (96) hours after Caesarean section. In this case, only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours is denied.~~

- ~~Healthy Blue may require notification by the provider of inpatient emergency admissions within one (1) business day of admission. Healthy Blue is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify the Louisiana Health Plan of inpatient emergency admission within one (1) business day of admission.~~

~~Healthy Blue shall not pay claims to or execute contracts with individuals or groups of providers who have been excluded from participation in federal health care programs or state funded health care programs. Healthy Blue shall not remit payment for services provided under the Contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.~~

Minnesota:

Per Minnesota Contract, section 6.13 Access Standards:

The MCO shall provide the same network of Providers for all Enrollees covered under this Contract. The MCO shall provide care to Enrollees through the use of an adequate number of primary care physicians, hospitals, service locations, service sites, and professional, allied and paramedical personnel for the provision of all Covered Services, pursuant to the following standards:

6.13.1 Primary Care.

6.13.1.1 Distance/Time. No more than thirty (30) miles or thirty (30) minutes distance for all Enrollees, or the STATE's Generally Accepted Community Standards.

6.13.1.2 Adequate Resources. The MCO shall have available appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of its Enrollees for covered services.

6.13.1.3 Timely Access. The MCO shall arrange for Covered Services, including referrals to Network and non-Network Providers, to be accessible to Enrollees on a timely basis in accordance with medically appropriate guidelines and consistent with Generally Accepted Community Standards.

6.13.1.4 Appointment Times. Not to exceed forty-five (45) days from the date of an Enrollee's request for routine and preventive care and twenty-four (24) hours for Urgent Care.

6.13.1.5 Tracking. The MCO must have a system in place for confidential exchange of Enrollee information with the Primary Care Provider, if a Provider other than the Primary Care Provider delivers health care services to the Enrollee.

6.13.2 Specialty Care.

6.13.2.1 Transport Time. Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

6.13.2.2 Appointment/Waiting Time. Appointments for a specialist shall be made in accordance with the time frame appropriate for the needs of the Enrollee, or the Generally Accepted Community Standards.
6.13.3 Emergency Care.
All Emergency Care must be provided on an immediate basis, at the nearest equipped facility available, regardless of whether the hospital is in the MCO Provider Network.
6.13.4 Hospitals.
Transport Time. Not to exceed thirty (30) minutes, or the STATE's Generally Accepted Community Standards.
6.13.5 Dental, Optometry, Lab, and X-Ray Services.
6.13.5.1 Transport Time. Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.
6.13.5.2 Appointment/Waiting Time. Not to exceed sixty (60) days for regular appointments and forty-eight (48) hours for Urgent Care. For the purposes of this section, regular appointments for dental care means preventive care and/or initial appointments for restorative visits.
6.13.6 Pharmacy Services.
Transport Time. Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.
6.13.7 Other Services.
All other services not specified in this section shall meet the STATE's Generally Accepted Community Standards or other applicable standards.
6.13.8 Around-the-Clock Access to Care.
The MCO shall make available to Enrollees access to Medical Emergency Services, Post-Stabilization Care Services and Urgent Care on a twenty-four (24) hour, seven-day-per-week basis. The MCO must provide a twenty-four (24) hour, seven day per week MCO telephone number that is answered in-person by the MCO or an agent of the MCO. This telephone number must be provided to the STATE. The MCO is not required to have a dedicated telephone line.

Nevada:
7.6.3.9.3. For specialty referrals to physicians, therapists, Behavioral Health Services, vision services, and other diagnostic and treatment Providers, the Contractor must provide:

Same day emergency appointments within twenty-four (24) hours of Referral;
Urgent appointments within three (3) Calendar Days of Referral;
Routine Appointments within thirty (30) Calendar Days of Referral; and
Access to a child/adolescent Specialist(s) if requested by the parent(s).

7.6.3.9.4. Initial Prenatal Care Appointments must be provided as follows:
First trimester within seven (7) Calendar Days of the first request;

Second trimester within seven (7) Calendar Days of the first request;
Third trimester within three (3) Calendar Days of the first request; and
High-risk pregnancies within three (3) Calendar Days of identification of high-risk by the Contractor or maternity care Provider, or immediately if an emergency exists.

A pcp may be a specialist or a provider who is overseeing the care for any member who has case management needs such as womens health and OB care, behavioral health, and children/adults with special health care needs. (7.5.6.7.13.1.4)

Members must be allowed to self-refer for family planning (in or Out-of-Network), and obstetrical, gynecological, mental health and substance abuse services within the Contractor's Network (7.6.3.5.1.4).

New Jersey:
In New Jersey, PCP is defined as Primary Care Provider.

If the information does not meet medical necessity criteria for specialty care that requires prior authorization, the authorization is pended to the Medical Director for review.
The MCO is responsible for assisting the member, family, facility or school in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long term care facility, skilled nursing facility or school and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. The provider must submit documentation to the MCO of all locations they visit and serve and include the days and times for each location, except when a visit is to a residence.
The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements.

Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a "brick and mortar" facility located in New Jersey that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Enrollees). They must demonstrate their ability to render dental treatment services and assist with dental referrals as needed.

The contractor must monitor on an annual basis the standard of dental care rendered and ensure that needed referrals for dental treatment that cannot be provided by a mobile dental practice occur. Dental services may be provided in these settings through the following modalities.

- Mobile Dental Practice (utilizing portable equipment – is a provider traveling to various locations and utilizing portable dental equipment to provide dental services outside of a dental office/clinic in settings to include but not limited to facilities, schools and residences.
- Facilities: These providers are expected to provide on-site comprehensive dental care (to include intra-oral radiographs), necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care.
- Schools: These locations are not considered a dental home and are limited to providing the following services: oral assessment/screening, prophylaxis, fluoride treatment, emergency care and referral to the member's dental home when known or their MCO for assistance in locating a dentist.
- Private Residences and other residential settings: These providers are expected to provide on-site dental care for the homebound based on patient safety and ability to tolerate procedures outside of a clinical setting.

New York:
PCP is defined as Primary Care Provider.
The health plan's participating provider must make sure that for all members under age 21 all appropriate diagnostic and treatment services, including specialist referrals are furnished pursuant to findings from a C/THP screen. (MCD/FHP Contract Section 10)

The health plan does not complete SCA but instead refers providers through BlueCard services for out of state providers: instate providers are asked to contact local blues plan for reimbursement discussion.

New York Western:
The Western New York Health Plan and its Participating Providers must comply with the C/THP program standards and must do at least the following with respect to all members under age 21.

a) Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up with children and adolescents who miss or cancel appointments. This also applies to dental service appointments for children and adolescents.
b) Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen.

Tennessee:

The TN HCM associate attempting to locate an out-of-network provider for the member will coordinate efforts with Provider Solutions by entering a request on the Operations T-NART SharePoint site. The request will be assigned to a Provider Solutions representative who will collaborate with HCM in acquiring an accepting specialist and evaluate the need for additional contracting of the requested specialty.

The TN HCM UM clinician does not initiate a SCA unless the Provider will not accept OON rates and requests a SCA be initiated for negotiated rates. If a SCA is needed for the out of network provider, the TN HCM/CST Associate will verify that the provider has a TN Medicaid ID and a Disclosure of Ownership (DOO) on file to process reimbursement.

Texas:
Pursuant to the Texas Uniform Managed Care Contract (UMCC), Section 8.1.3 "Access to Care", the MCO must provide that if medically necessary covered services are not available through network providers, the MCO must, upon the request of a network provider, allow a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the member, but in no event to exceed five (5) business days after receipt of reasonably requested documentation. The MCO must fully reimburse the non-network provider in accordance with the out-of-network methodology for Medicaid as defined by HHSC in 1 TAC §353.4, and for CHIP, at the usual and customary rate defined by TDI in 28 TAC §11.506.

UMCC Section 8.1.4.2, "Primary Care Providers", requires that the MCO must require PCPs, through contract provisions, to assess the medical needs of members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate members' care with specialty care providers after referral. The MCO must make best efforts to ensure that PCPs assess member needs for referrals and make such referrals.

UMCC Section 8.1.3.1, "Appointment Accessibility" requires specialty routine care to be provided within 21 days and within 24 hours for urgent specialty care.

UMCC Section 8.1.12.2," Access to Care for MSHCN" states that the MCO must have a mechanism in place to allow members with Special Health Care Needs (MSHCN) to have direct access to a specialist as appropriate for the member's condition and identified needs, such as a standing referral to a specialty physician or Behavioral Health provider. The MCO must also provide MSHCN with access to non-primary care physician specialists as PCPs, as required by 28 TAC §11.900 and UMCC section 8.1.4.2, "Primary Care Providers."

Members can get the following services without a referral if covered under their benefit plan:
- Emergency care
- Behavioral health services (mental health and/or substance abuse) from a health plan

behavioral health services provider
- Family planning from any health plan network or state-approved Medicaid family planning provider
- Prenatal care from a health plan network obstetrician or certified nurse midwife
- Eye exams from a health plan network eye care provider (optometrist)
- Screening or testing for sexually transmitted diseases, including HIV from a health plan network doctor
- Texas Health Steps (formerly EPSDT) medical checkups from a Texas Health Steps provider for children birth through age 20
- Early childhood intervention services
- Services of a Rural Health Clinic, Federally Qualified Health Center, or public clinic outside of normal business hours
- OB/GYN services from a health plan network provider

Prior Authorization Requests from Out-of-Network Providers:
Exception to Section 2) of Corporate Policy: If the out-of-network provider will not accept the Texas out-of-network provider rates, the case is routed to the health plan for a single case agreement (SCA) upon provider request.

Washington:
For the WA Foundational Community Supports per 7.1.1 To the extent necessary to comply with the provider network adequacy and distance standards required under this Contract, the Contractor may offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure timely access to necessary services and must coordinate with Oregon and Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access services when service is appropriate, available, and cost-effective.

Amerigroup shall provide all medically necessary contracted specialty care for members in a service area, such as services a member may need to support Gender Affirming Care and Care Coordination to secure out-of-network services.

Wisconsin:
Special Conditions: a (1) life threatening, degenerative or disabling condition or (2) required specialized medical care over a prolonged period of time.

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

For members with special health care needs, where it has been determined to need a course of treatment or regular case monitoring, the health plan of Wisconsin must have mechanisms in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs.
For members with special conditions 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.

The health plan of Wisconsin 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, in addition to direct access to a primary medical provider for routine services, if the primary medical provider is not a women's health specialist. The health plan ensures access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.

REVISION HISTORY:

Review Date	Changes
10/14/13	• Rebranded for VA Medicaid Migration. Remove company specific references.
01/01/14	• Added Kentucky health plan.
04/01/14	• Added Wisconsin as applicable health plan and removed New Mexico. Added WI exception language and removed NM exception language.
11/14/14	• Added Exception Language for Louisiana based on 2015 Contract
06/18/15	• Biennial review by PPOC. Update references to Healthcare Management Services to Health Care Management, add Medicare tag line, add definitions, add #4 under procedures – Non-Par provider, add Medicaid screening requirement attachment, and add language to KY & TX exceptions.
12/03/15	• Off-cycle edits to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.
12/01/16	• Off-cycle edits to add New York – Western as an applicable market and add NY – Western and TX DCHP/Seton exception language.
01/18/17	• Off-cycle edit to Iowa contract reference and Iowa exception language
06/29/17	• Biennial review • Added IN as an applicable market • Added Medicare & MMP as applicable products • Added NY & TN exceptions

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management	**Specialty Referral**

Review Date	Changes
08/10/18	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
10/18/18	• Off-cycle change to reflect new FL AHCA Contract No. 068 signed 08/01/2018 and effective 12/01/2018. • Rebranding all FL Medicaid plans to Simply Healthcare Plans or Clear Health Alliance d.b.a. Simply Health Care Plans.
12/13/18	• Off-cycle edit to add DC as an applicable market. Update MN go-live date to 1/1/19.
01/25/19	• Off-cycle edit to add AR as an applicable market. No content edits.
07/25/19	• Annual Review • Placed on updated template • Updated Policy section • Updated Procedure • Revised FL, KY, LA & MN exceptions
09/27/19	• Off-cycle Review • NJ Contract Amendment/Contract Sections 4.5 and 4.5.1 • Revised NJ exception
02/03/20	• Off cycle review; revised for new LA Emergency Contract • Updates to LA exception section
08/27/20	• Annual Review (switched from biennial) • Revised Procedure and References • Placed Related Policies and Procedures in alphabetical order • Revised TN exception • Added WA exception
11/11/20	• Off-Cycle Review • Added AR exception and reference
02/12/21	• Off-Cycle review • Added FL FHK Exception and Reference
08/26/21	• Annual Review • Added NC as an applicable market • Removed DC as an applicable market • Updated Policy, Procedure and References • Added Medicare exception • Revised KY, NJ and TX exceptions
09/28/21	• Off-Cycle Review • Added Policy Number
12/07/21	• Off-Cycle Review • NV Rebid

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Review Date	Changes
	• Added NV exceptions
08/25/22	• Annual Review • Added MO as an applicable market • Updated Policy, Procedure and References • Placed Exceptions in alphabetical order • Added GA exception • Revised NV, TX and WA exceptions
09/29/22	• ~~Model Contract RFP readiness review~~Off-Cycle Review for LA Rebid Readiness Review • Revised LA Exceptions and added LA References