Section (Primary Department) **Health Care Management**	**SUBJECT (Document Title)** **Standing Referral - LA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
January 1, 2012	September 1, 2022	~~October 7, 2021~~October 3, 2022	~~September 1, 2022~~October 3, 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 define the process for providing a standing referral when a member with a condition requires on-going care from a specialist, or 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.

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. The primary care provider (PCP) or member is assisted in determining the need for services and coordinating an appointment with an 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, and recommendations for care) and follow-up are included in PCP's member medical record. Healthy Blue must assist the PCP or enrollee with making an appointment. Contact information for accessing referral system services should be clearly outlined in provider and enrollee materials.

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

- When a referral from the enrollee's PCP is and is not required;
- Process for enrollee referral to an out-of-network provider when there is no provider within Healthy Blue's provider network who has the appropriate training or expertise to meet the particular health needs of the enrollee;
- Process for providing a standing referral when an enrollee with a condition requires on-going care from a specialist;

- Process for assisting PCPs find specialists when their attempts have been unsuccessful. This process shall include a form that can be faxed or securely e-mailed to Healthy Blue, with a 72 hour turnaround to the provider;
- Process for referral for specialty care for an enrollee with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;
- Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or an enrollee of the provider's family has a financial relationship; and
- Processes to ensure monitoring and documentation of specialty healthcare services and follow up are included in the PCP's enrollee medical record.

Healthy Blue shall develop electronic, web-based referral processes and systems.

Providers are required to make any necessary referrals of the enrollee to a specialist. Healthy Blue maintains an adequate provider network to support the provider in making the referrals and support the enrollee in accessing the services.

Providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the enrollee for care. Providers who refer the enrollee for care must make the necessary referrals at the time of screening. This information must be maintained in the enrollee's record.

Healthy Blue supports PCPs who screen enrollees for behavioral health issues and treat mild to moderate cases, including educating and training practices on how to treat common behavioral health conditions and providing clinical consultations and guidance for issues that do not require specialty referrals. Healthy Blue works to integrate physical and behavioral health services through (including, but not limited to):

- Educating enrollees and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;
- Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;
- Ensuring continuity and coordination of care for enrollees who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for enrollee(s) requiring behavioral health services;
- Documenting authorized referrals in Healthy Blue's clinical management system;
- Providing or arranging for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures;
- Working to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen

positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, adverse childhood experiences (ACEs), and substance use.

Each enrollee is guaranteed the right to receive this policy on referrals for specialty care and other benefits not provided by the enrollee's PCP.

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

~~**Benefits or Covered Services –** Those Medicaid covered health care benefits and services to which an eligible Medicaid recipient is entitled under the Louisiana Medicaid State Plan, and that are required to be provided by Healthy Blue to enrollees.~~

Case Management (CM) – A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual enrollee's health-related needs through communication and available resources to promote quality and cost-effective outcomes. Case management implicitly enhances care coordination through the designation of a case manager whose specific responsibility is to oversee and coordinate access and care delivery targeted to high-risk patients with diverse combinations of health, functional, and social needs.

Case Manager – A licensed registered nurse, licensed mental health practitioner, or other trained individual who is employed or contracted by Healthy Blue or an enrollee's primary care provider (PCP). The case manager is accountable for ensuring appropriate referrals (refer to *Case Management – LA*).

Excluded Services – Those services which enrollees may obtain under the ~~Louisiana Medicaid~~ State Plan and for which Healthy Blue is not financially responsible.

In Lieu of Service (ILOS) – A medically-appropriate service outside of ~~benefits~~, Managed Care Organization (MCO) covered services or settings, or beyond service limits, established by LDH or MCO covered services, that are provided to enrollees, at their option, by Healthy Blue as a cost-effective alternative to an MCO covered service or setting.

Managed Care Organization (MCO) Covered Services – Those Medicaid covered services that are required to be provided by the MCO to enrollees as specified in *Attachment C, MCO Covered Services*, of the Contract.

Medicaid Covered Services – Those health care benefits and services to which an eligible beneficiary is entitled under the State Plan.

Network Provider or Provider* – An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors that has

a signed provider agreement with Healthy Blue for the delivery of MCO Covered Services to Healthy Blue's Enrollees.

Non-Participating or Out-of-Network Provider – A provider that does not have a signed provider agreement with Healthy Blue for the delivery of MCO covered services to Healthy Blue's enrollees.

~~**Non-Participating Provider –** A provider that does not have a signed network provider agreement with Healthy Blue.~~

Primary Care ~~Physician or~~ Provider (PCP) – An individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of an ~~member's~~ enrollee's health care. The PCP is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

Primary Care Services – Health care services and laboratory services customarily furnished by or through a PCP for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through direct service to the Enrollee when possible or through appropriate referral to specialists and/or ancillary providers.

Referral Services – Health care services provided to enrollees ~~members~~ to both in- and out-of-network providers when ordered and approved by Healthy Blue, including, but not limited to in-network specialty care and out-of-network services which are covered under the ~~Louisiana Medicaid~~ State Plan.

Specialist – A physician ~~specialist/subspecialist is a healthcare professional~~ who is not a primary care ~~physician~~ provider (PCP). May be used interchangeably with subspecialist.

Tertiary Care – Highly specialized medical care, usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Utilization Management (UM) – Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. Utilization management is inclusive of utilization review and service authorization.

PROCEDURE:

1) Healthy Blue does not require referrals to in-network specialists.

2) 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.
   a) Prior authorization is required for all non-emergency referrals or transfers to ~~t~~-out-of-network specialists (refer to the Exceptions section of this policy; an related policies in the references section for authorization guidance.) ~~*Out-of-Area, Out-of-Network Care – LA* and *Out-of-Network Authorization Process*).~~
   b) At a minimum, the following resources shall be utilized to screen out-of-network and/or non-participating providers:
      i) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
      ii) The System of Award Management (SAM);
      iii) Louisiana Adverse Actions List Search; and
      iv) Other applicable sites as may be determined by LDH.
3) When a member has~~with~~ an illness, life-threatening condition or disease requires on-going or prolonged care from a specialist, a standing referral may be requested.
   a) The PCP or specialist must submit a written request by fax, web portal, or secure e-mail including:
      i) The member's primary and secondary diagnoses (if applicable);
      ii) The number and frequency of visits requested;
      iii) An individualized, comprehensive treatment plan including, but not limited to:
         (1) Identification of special health care needs;
         (2) Outpatient, ~~and~~ inpatient, and medication management;
         (3) Ambulatory surgery or other outpatient procedures;
         (4) Diagnostic testing;
         (5) Transportation; and
         (6) Consultations with any specialists.
4) Upon receipt of required documentation, standing referral requests are reviewed by the interdisciplinary clinical team.
   a) A Utilization Management (UM) reviewer coordinates review of the submitted documentation with Heathy Blue's Medical Director.
   b) The Medical Director may consult with the PCP, specialist, member or member's designee, and/or case manager during the review and consideration period.
   c) The course of treatment proposed must be consistent with the member's diagnosis and identified medical needs.
   d) The Medical Director will make the decision to approve the treatment plan as submitted or may decide to limit the number of visits, scope of services, or the period during which the services are authorized.
   e) Authorized referrals are documented in the UM system.
   f) A standing referral may be approved for a duration of three (3) to six (6) months.
   g) Consideration to authorize continued services ~~Reauthorization~~ at the end of the initial authorization period will include review of an updated treatment plan.

h) Healthy Blue is not required to permit the member to elect an out-of-network provider except in cases of continuity of care and as contractually mandated.

i) If a standing referral is limited or denied, the member or member's designee, the PCP, and the specialist are notified in writing of the reason for denial and rights to an appeal.

5) Healthy Blue monitors r~~R~~eferrals and conducts medical record reviews. D~~d~~ocumentation of referrals to specialty health care services and ~~are monitored and~~ follow-up must be 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.

6) Should the member decide, for any reason, to change specialists after a standing referral has been granted, the member or member's designee must contact Healthy Blue to advise of the change. The new specialist is required to complete the standing referral process, including submission of a request and review of the required documentation outlined in this procedure.

7) Information for accessing referral system services and the process for obtaining standing referrals is included in the member and provider materials (e.g., Member and Provider Handbooks), on the Healthy Blue website, and by calling Member or Provider Services. (refer to *Utilization Management – LA* for a list of excluded services).

~~8)~~ Members are informed about how to access excluded services that are available under the Louisiana State Plan and applicable waivers, but not provided through Healthy Blue (refer to *Non-Covered and Cost-Effective Alternative Services – LA*). Healthy Blue provides all required referrals and assists in the coordination of scheduling of such services.

~~a) The following services are provided through fee-for-service (FFS) Medicaid:~~

~~ii) Dental services, with the exception of varnish provided in a primary care setting, surgical dental services, and emergency dental services;~~

~~iii) Services to individuals in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);~~

~~iv) Personal care services for those ages twenty-one (21) and older;~~

~~v) Nursing facility services, with the exception of post-acute rehabilitative care provided at the discretion of Healthy Blue when it is cost-effective to do so in place of continued inpatient care as an ILOS;~~

~~vi) Individualized Education Plan (IEP) Services, including physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy, provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by the Office of Public Health (OPH) certified school-based health clinics);~~

~~vii) All Home & Community-Based Waiver services;~~

~~viii)Targeted Case Management services; and~~

~~ix)~~i)~~Services provided through LDH's Early Steps Program (Individuals with Disabilities Education Act (IDEA), Part C Program Services).~~

With LDH approval, Healthy Blue may, at its option, cover services or settings for members that are in lieu of MCO covered services. Refer to *Utilization Management – LA, Managed Care Organization Manual – LA*, and applicable Behavioral Health and Marketing resources for additional details and ILOS requirements.

~~9) if the following conditions are met, as required in 42 CFR §438.3(e)(2)(i) (iii):~~

~~a) LDH determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State Plan;~~

~~b) The member is not required by Healthy Blue to use the alternative service or setting; and~~

~~c) The approved ILOS are authorized and identified in *Attachment D, Rate Certification*.~~

~~d) The utilization and actual cost of ILOS is taken into account in developing the component of the capitation rates that represents the core benefits and services, unless a statute or regulation explicitly requires otherwise.~~

~~e) Healthy Blue may submit additional ILOS to LDH for prior approval. The submission shall include a plan for identifying and reporting the utilization of the ILOS.~~

REFERENCES:

- ~~Behavioral Health Continuity and Coordination of Care~~
- CFR Title 42
- ~~Continuity of Care – LA~~
- ~~Coordination of Care – LA~~
- Louisiana Medicaid ~~State~~ Managed Care Organization Contract
- Louisiana Medicaid Managed Care Organization Manual
- ~~Non-Covered and Cost-Effective Alternative Services – LA~~
- ~~Out-of-Area, Out-of-Network Care – LA~~
- ~~Out-of-Network Authorization Process~~
- ~~Precertification of Requested Services – LA~~
- ~~Specialty Referral~~

Related Policies:

- Behavioral Health Continuity and Coordination of Care – LA
- Case Management – LA
- Continuity of Care – LA
- Coordination of Care – LA
- GBD-HCM-003 Clinical Information for Utilization Management Reviews – Core Process
- GBD-HCM-010 Non-Covered and Cost-Effective Alternative Services
- GBD-HCM-011 Out-of-Network Authorization Process
- GBD-HCM-014 Specialty Referral

- GBD-UM-014 Out-of-Area, Out-of-Network Care
- GBD-UM-017 Pre-Certification of Requested Services – Core Process
- GBD-UM-023 Stand for Medical Records Review
- GBD-UM-127 Continuity of Care – Core Process
- Managed Care Organization (MCO) Manual – LA
- Utilization Management – LA
- Women's Health and Family Planning Services – LA

See Marketing, Provider Network and Relations, and Quality Management policies or other materials for further compliance with referral system requirements and guidelines.

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management

Secondary Department(s):
Behavioral Health
Marketing
National Customer Care
Operations- Claims
Pharmacy
Provider and Network Relations
Quality Management

EXCEPTIONS:

- 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.
- Healthy Blue shall not require a PCP referral for in-network eye care and vision services.
- 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 a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the plan for routine and preventive women's healthcare services and prenatal care.
- Healthy Blue ensures that its enrollees have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside Healthy Blue's provider network without any restrictions, as specified in 42 Code of Federal Regulations (CFR) §431.51(b)(2). Enrollees have the opportunity to use their own PCP or utilize any family planning service provider for family planning services without a referral

or authorization.

- Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.
- Emergency services, including those for specialized behavioral health, are rendered without the requirement of prior authorization of any kind. Healthy Blue covers and pays for emergency services regardless of whether the provider that furnishes the emergency services is part of Healthy Blue's provider network.

- 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) 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 and disenrollment procedures.
- .Healthy Blue shall not avoid costs for services covered in its contract by referring enrollees to ~~publically~~publicly supported health care resources (42 CFR §457.1201(p)).

- Healthy Blue shall not pay claims to or execute contracts with individuals or groups of providers who have been excluded from participation in F~~f~~ederal health care programs under either 42 USC §1320a-7 or §1320a-7a (42 CFR §438.214(d)) 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.

~~Exceptions to referral and authorization requirements:~~

~~1) 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.~~

~~2)1) Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.~~

~~3)1) Healthy Blue shall not require service authorization or referral for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening services.~~

~~4) 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.~~

~~5) 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.~~

~~6)1) 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 plan for routine and preventive women's healthcare services and prenatal care.~~

~~7)1) Healthy Blue shall not require a PCP referral for in-network eye care and vision services.~~

~~8) Healthy Blue may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.~~

~~9) 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.~~

~~10) 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.~~

~~11) 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 of inpatient emergency admission within one (1) business day of admission.~~

~~Refer to *Non-Covered and Cost-Effective Alternative Services – LA* for additional information regarding excluded, non-covered, and in lieu of services.~~

REVISION HISTORY:

Review Date	Changes
11/11/2014	• Purpose and references updated per LA 2015 Readiness Review
09/08/2015	• Louisiana State Contract Amendment 4 Behavioral Health Changes
11/11/2016	• Annual review • Update contract verbiage and Amendments 5 and 6 • Referral definition added and placed in alphabetical order • Policy section updated
11/08/2017	• For annual review • Amerigroup references updated to Healthy Blue
11/02/2018	• For annual review • No changes
11/19/2019	• Annual Review

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management	**Standing Referral - LA**

Review Date	Changes
	• Edits within policy, procedure, and reference section • Placed on updated template
02/24/2020	• Off cycle review; revised for new LA Emergency Contract • Edits to the policy, definitions, and procedure sections • Exception section added • References updated • Behavioral Health, National Customer Care Organization, Pharmacy, Provider Relations, Quality Management added as secondary departments
10/30/2020	• Annual Review; no changes
10/07/2021	• Annual Review • Removed NCC as a secondary department
09/01/2022	• Annual Review; no content changes • Moved exceptions to correct place on template
10/03/2022	• Off-Cycle Review for LA Rebid 2023 Readiness Review • Updated for 2023 Model Contract Readiness Review • Revised for MCO Manual 3.0- Part 9 Provider Network • Updated policy, definitions, procedure, references, and exceptions • Added related materials • Added Marketing, National Customer Care, Operations - Claims, and Network Relations as secondary departments