Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management**	**SUBJECT (Document Title)** **Standing Referral~~s~~ – LA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
January 01, 2012	November 19, 2019~~February 24, 2020~~	~~November 19, 2019~~February 24, 2020	~~November 19, 2019~~February 24, 2020
Department Approval/Signature ~~:JS~~			

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

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

POLICY:

To define the process for providing a standing referral when a~~by which providers/specialists of our~~ member~~s~~ with a ~~life-threatening~~ condition ~~or disease that~~ requires on-going~~specialized~~ 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 ~~from a specialist may request a standing referral to such specialists to ensure access and timeliness of care~~.

~~The MCO~~Healthy Blue shall have a referral system for ~~MCO~~ members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. ~~The MCO shall~~Healthy Blue provides the coordination necessary for referral of ~~MCO~~ members to specialty providers. ~~–~~The primary care provider (PCP) or member~~MCO shall~~ is assisted ~~the provider or member~~ in determining the need for services and coordinating an appointment with an ~~outside the MCO network and refer the member to the~~ appropriate service provider. ~~-~~The referral system ~~must~~ 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.

~~The MCO shall submit referral system policies and procedures for review and approval within 30 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 member' PCP is and is not required (See Section 8.5.4.2 Exceptions to Requirements);~~
- ~~Process for member referral to an out-of-network provider when there is no provider within the MCO's 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 member referral for case management;~~
- ~~Process for member referral for chronic care management;~~

DEFINITIONS:

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.

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, covered services or settings, or beyond service limits, that are provided to enrollees, at their option, by Healthy Blue as a cost-effective alternative to a covered service or setting.

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 a member's health care. The ~~primary care provider~~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.

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

Specialist~~/Specialty Services~~ – A specialist/subspecialist is a health-care professional who is not a primary care physician (PCP).

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.

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-emergent out-of-network specialists (refer to *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 with an illness, life-threatening condition or disease requires on-going or prolonged care from a specialist, a standing referral may be requested.
   ~~1) Requests for Standing Referrals~~
   a) The PCP or specialist must submit a written request by fax or secure e-mail including:
      i) The member's ~~P~~primary and secondary diagnoses (if applicable);
      ii) The ~~N~~number and frequency of visits requested;
      iii) A comprehensive ~~T~~treatment plan including, but not limited to:
         (1) Identification of special health care needs;
         ~~(1)~~(2) Outpatient and inpatient management;
         ~~(2) Inpatient management~~
         (3) Ambulatory surgery or other outpatient procedures;
         ~~(4) Transportation~~
         (4) Diagnostic testing;
         (5) Transportation; and
         (6) Consultations with specialists.

4) ~~Review of Standing Referrals~~Upon receipt of required documentation, standing referral requests are reviewed by the interdisciplinary clinical team.

~~2)~~
   a) ~~The HCM~~ A Utilization Management (UM) ~~R~~reviewer ~~Nurse will~~ coordinates review of the submitted documentation with Heathy Blue's Medical Director.
   ~~a)~~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. ~~Heathy Blue's Medical Director.~~
   ~~b)~~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.
   ~~c)~~e) Authorized referrals are documented in the UM system.
   ~~d)~~f) A standing referral may be approved for a duration of three (3) to~~or~~ six (6) months.

e)g) Re-authorization at the end of the authorization period will include a review of an updated treatment plan.

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

h)

g) Although standing referrals are authorized for a three (3) or six (6) month period, eligibility at the time of service is not guaranteed. It is the provider's responsibility to confirm eligibility prior to providing services.

h)i) If a standing referral is limited or denied by the Medical Director, Healthy Blue will notify 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. The notice will indicate how to file an appeal of the decision made.

5) Referrals and documentation of specialty health care services 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.

3) Process for changing specialists

a)6) Should the member decide, for any reason, to change specialists after a standing referral has been granted, the member or member's designee mustshould contact Healthy Blue the Louisiana health plan to advise of the change. The new specialistmember will then be is required to complete the standing referral process, for the new specialist including submission of a request and review of the required documentationrequest as outlined in this procedure.

4) Member information regarding standing referrals

7) Information for accessing referral system services andregarding the process for obtaining standing referrals iswill be included in the member and provider materials (e.g., Member and Provider hHandbooks), on the Healthy Blue website, and be available by phone via by calling Member or Provider Services at1-844-521-6941.

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:

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

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

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

iv) 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;

v) 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);

vi) All Home & Community-Based Waiver services;

vii) Targeted Case Management services; and

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

9) Healthy Blue may, at its option, cover services or settings for members that are in lieu of MCO covered services 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.

~~a)~~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.

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.

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. Healthy Blue shall not avoid costs for services covered in its contract by referring enrollees to publically supported health care resources.

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.

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) Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.
3) 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) 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) 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.

REFERENCES:

Behavioral Health Continuity and Coordination of Care
CFR Title 42
Continuity of Care – LA
Coordination of Care – LA
~~Healthy~~ Louisiana State Contract ~~Section, 6.28.2.3, 6.28.2.4, 6.29.1, 6.29.2 and 8.5.4.2.~~
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

RESPONSIBLE DEPARTMENTS:

Primary Department:~~-~~ Health Care Management

Secondary Department(s): Behavioral Health, National Customer Care Organization, Pharmacy, Provider Relations, Quality Management

~~**EXCEPTIONS:**~~

~~None~~

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 • Edits within policy, procedure, and reference section • Placed on updated template
~~12/24/2019~~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