POLICY AND PROCEDURE	
Policy # and TITLE: Standing Referral/Extended Access to Specialty Care	
Primary Policy owner: Utilization Management	**POLICY #:** UM11
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☒Behavioral Health & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☒ Care Management (CM) 5) ☐ Claims (CLMS) 6) ☐ Community Marketplace & Member Engagement (MAR) 7) ☐ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☐ Cultural & Linguistics (CL) 11) ☐ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☐ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☒ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☒ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** N/A

I. PURPOSE

Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") members may receive a standing referral to a Specialist or specialty care center coordination if medically necessary.

II. POLICY

A. Health Plan's Primary Care Providers (PCP) may request a standing or extended access referral to a non-network Specialist or a specialty care center for a member who has ongoing specialty care needs in

accordance with Health Plan Policy UM01 Authorizations and Referrals.

1. Health Plan does not require prior authorization for in-network specialty referrals.
2. Should ongoing specialty care be required from an out of network (OON) or out of area (OOA) specialist, prior authorization is required.
3. A treatment plan may not be necessary provided that a current standing referral to a specialist or specialty care center has been approved. A treatment plan may limit the number of visits, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member.

B. A standing or extended access referral will be approved, when medically necessary to a specialist or specialty care center for a member who requires specialized medical care over a prolonged period of time and has a life threatening, degenerative or disabling condition. Health Plan will decide regarding prior authorization requests for standing referrals within three (3) business days of the date when the request is made by the member or their PCP, and all appropriate medical records and other information necessary to make the determination are provided. Once a determination is made, the referral must be made within four (4) business days of the date the treatment plan, if any, is submitted to the medical director.

C. The standing referral can be approved for up to one year.

D. Conditions necessitating a standing or extended access referral and/or the development of a treatment plan are interpreted broadly as a "condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative or disabling" and could include but are not limited to the following:

1. Hepatitis C
2. Lupus
3. HIV/AIDS
4. Cancer
5. Potential transplant candidates
6. Severe and progressive neurological conditions

7. Renal Failure
8. Cystic Fibrosis
9. Acute Leukemia
10. High-risk Pregnancy

E. PCPs are responsible for coordinating a standing or extended access referral to Specialty Care with the member in consultation with the Specialist.

F. Any procedure ordered by the Specialist will follow the prior authorization process according to Health Plan Policy UM01 Authorization and Referral Process.

III. PROCEDURE

A. Extended Access to Specialty Care

1. The PCP shall request authorization for an extended access/ standing referral for specialized medical care in consultation with the Specialist, when a member with a condition or disease that requires such care as described in Section II. C of this Policy.
    a. The member's significant medical condition(s) requiring frequent or repeat visits to a Specialist should be documented in the medical record by the PCP.
2. After the referral is made, the Specialist shall be authorized, when medically necessary, to provide specialty care services to the member in the same manner as the member's primary care physician, subject to the terms of the treatment plan.

B. Out of Network

1. Health Plan will refer members to contracted specialists or specialty care center unless there is no specialist or specialty care center within the plan network that is appropriate to provide treatment to the member, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan.

C. Standing Referral To HIV/AIDS Specialist

1. A standing referral to an HIV/AIDS Specialist will be made to a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following three criteria: (which will be validated during the re-credentialing period)
    a. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or
    b. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
    c. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
        i. In the immediately preceding twelve (12) months has clinically managed medical care to a minimum of twenty-five (25) patients who are infected with HIV; and
        ii. In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year; or
        iii. Meets the following qualifications:
            A. In the immediately preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are infected with HIV; and
            B. Has completed any of the following:
                1. In the immediately preceding twelve (12) months has obtained board certification or recertification

in the field of infectious diseases from a member board of the American Board of Medical Specialties; or

2. In the immediately preceding twelve (12) months has successfully completed a minimum of thirty (30) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.
4. A referral can be made to an HIV/AIDS specialist for the purpose of diagnosis, treatment, or management of HIV services.
5. The HIV/AIDS Specialist may utilize the services of a nurse practitioner or physician assistant if:
    a. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS Specialist; and
    b. The nurse practitioner or physician assistant meets the qualifications specified above in section c iii.; and
    c. The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS Specialist have the capacity to see an additional patient.

6.	PS J	Medical Management or Provider Services will assist PCPs in identifying HIV Specialists if needed

IV. ATTACHMENT(S)

A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
B. Glossary of Terms Link
C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

A. DHCS Contract Exhibit A, Attachment III, 2.3 Utilization Management Program
B. Health & Safety Code, Section 1374.16, 1363.5, 1367.01, and 28 CCR sections 1300.70(b)(2)(H) and (c).
C. Health Plan Policy UM 01, Authorization and Referral Review

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
000	03/01, 04/02, 05/06, 10/08, 02/11, 01/15, 01/17, 05/18, 02/19, 05/20, 07/21, 03/23	N/A
001	Moved policy to new template	5/3/2024
002		
Initial Effective Date: 1/1/1999		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	001	5/16/2024
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		

• Audits & Oversight Committee		
• Policy Review	001	5/15/2024
Quality and Utilization Management		
• Quality Operations Committee		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	MCOD Operational Readiness	001	8/10/2023
Department of Managed Care (DMHC)	DMHC Attorney	001	4/26/2024

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy