PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3124</td><td colspan="4">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Referral to Specialists (RAF) Policy</td><td colspan="4">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: (UM-1) 12/27/1995
(Effective 08/21/2013 - RAF Review Policy split from TAR/RAF Review)</td><td colspan="5">Next Review Date: 04/09/2026
Last Review Date: 04/09/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 04/09/2025</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3039 – Direct Members
C. MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
D. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
E. CGA024 – Medi-Cal Member Grievance System
F. MPNET100 – Access Standards and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity: Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
B. Partnership Provider Network: Providers that are contracted with Partnership HealthPlan.
C. Referral Authorization Form (RAF) process: is defined as the process by which the primary care provider (PCP) submits a request to Partnership HealthPlan of California to refer a Partnership enrollee to a specialist for evaluation and/or treatment.
D. Tertiary Medical Care: is specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special investigation and treatment.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the procedure used by the Partnership Utilization Management (UM) Department to process Referral Authorization Forms (RAFs) based upon the medical necessity of the request.

VI. POLICY / PROCEDURE:

A. Members assigned to a primary care provider (PCP) must have an approved RAF on file for the

Partnership Claims Department to reimburse the specialist for elective/scheduled services rendered. RAFs are not required for members who have another insurance plan as the primary carrier or are assigned a Partnership Direct Member status (see policy MCUP3039 Direct Members.)

B. Specialist to Specialist Referral
   1. A specialist may request a referral to another specialist from the primary care provider ONLY under the following circumstances:
      a. Referral must be within the same specialty field as the specialist
      b. Referrals must be for emergent or urgent conditions only
      c. Referral must be sent to the member's PCP to submit to Partnership

C. Obstetric/Gynecological (OB/GYN) Services
   1. OB/GYN services do not require a RAF.
      a. During obstetrical care, the Member may be referred to obstetrical subspecialty service providers without a RAF for medically necessary obstetrical services (e.g. amniocentesis, perinatology services, etc.)
      b. A RAF must be submitted by the PCP when a pregnant Member requires specialty services outside of perinatal subspecialties.

D. Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Services
   1. Members have the right to obtain out-of-network CNM and/or CNP services if the services are not available in-network.

E. Complex Cancer Treatment
   1. The California Cancer Care Equity Act allows members diagnosed with a complex cancer to request a referral to access medically necessary services from a National Cancer Institute (NCI)-designated comprehensive cancer center, an NCI Community Oncology Research Program (NCORP)-affiliated site, or a qualifying academic cancer center.

F. Indian Health Services (IHS)
   1. Partnership allows for access to both in-network and out-of-network IHS providers without requiring a referral from a network PCP or prior authorization.
      a. IHS providers, whether in-network or out-of-network, can refer members directly to network providers without requiring a referral from a network PCP or prior authorization.

G. Referral to a Specialist Outside of Partnership's Network
   1. PCPs are expected to make every effort to direct the Member to an in-network specialist within Partnership's service area. Partnership also may have contracting specialists outside its service area. The PCP and/or their referral coordinator can find contracting provider information on Partnership's Provider Online Services Portal.
   2. A referral request to an out-of-network specialist requires additional documentation and clinical review. The following must be submitted:
      a. Evidence of exhaustion of Partnership's contracted specialists in the provider network (e.g. denial letters, referral denials) within the member's county of residence or 60 miles driving distance (whichever is greatest). Partnership may provide transportation if the referral is approved and Member meets criteria for transportation benefit. See policy MCCP2016 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).
      b. Clinical documentation supporting the medical necessity for a referral to a non-contracting provider such as History and Physical, PCP progress notes, letter from PCP.
      c. Referrals to out-of-network specialists will only be approved when the out-of-network specialist has a demonstrated specialized skill or training that contracted, in-network specialists do not have.
   3. When a PCP requests a referral to an out of network specialist, Partnership's clinical staff will

review the request to determine if an in-network specialist is available. If an in-network specialist is identified, the case is reviewed by Partnership's Chief Medical Officer (CMO) or Physician Designee to determine if redirection to the in-network specialist is medically appropriate. If the determination is made that the Member should be redirected to an in-network specialist, the PCP is notified and provided with possible alternative in-network specialist(s). The Member is also notified of the determination and both the Member and PCP are provided the right to file a grievance or appeal (refer to Partnership policies CGA024 Medi-Cal Member Grievance System and MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions).

4. Partnership will coordinate services when an out-of-network provider is medically necessary. Coordination may include, but is not limited to, entering into a single case agreement with the provider and coordinating transportation if the Member meets criteria as per Welfare and Institutions Code (WIC) 14197.04 and/or Partnership policy MCCP2016 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).
    a. In the event that timely access to an appointment is not available as per access standards (see policy MPNET100 Access Standards and Monitoring), Partnership will authorize and arrange for out-of-network access to appointments.

H. Referral to a Tertiary Care Center Outside of Partnership's Network
1. If a PCP submits a request to refer a Member to an out of network tertiary care center, the medical records are reviewed by Partnership's Chief Medical Officer (CMO) or Physician Designee to evaluate the medical necessity for the tertiary level of care.
2. If the CMO or Physician Designee determines that the services could be provided at an alternative level of care, the PCP is notified of the determination and the right to request a peer to peer discussion with the reviewing physician. The Member is notified of the determination and provided with information on how to file a grievance or appeal (refer to Partnership policies CGA024 Medi-Cal Member Grievance System and MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions).

I. Standing Referrals
1. A Member with a condition or disease that requires an extended access referral for specialized medical care may receive an extended referral to a specialist or specialty care center that has expertise in treating the condition or disease.

J. Referral Authorization Process
1. A PCP should submit the RAF electronically using Partnership's Online Services (OLS) portal. Electronic submission allows for the most expedient processing. If online submission is not possible, the RAF may be submitted via fax or mail to Partnership's Health services department for review.
2. Referrals to contracted specialists are auto adjudicated and written approval is generated to the requesting PCP and specialist within one working day of the receipt of the request.
3. All referrals to non-contracted providers will be reviewed for medical necessity as described in section VI. E above.
4. An electronic copy of the RAF determination is sent via electronic fax to the referring PCP.
5. If a RAF is determined to be pended, modified, or denied, a notification letter is mailed to the Member and also faxed to the PCP.
6. In general, there are no limits to the number of visits, but in certain circumstances, such as transitioning care back to local specialist or if a pattern of over-utilization is noted on retrospective review, then Partnership may impose limits on the number of visits or time period covered by the RAF. At the end of approved time period, a new RAF from the PCP will be required.

K. Treatment Authorization Requirements
1. If the services to be rendered require a Treatment Authorization Request (TAR) from Partnership, it

is the responsibility of the rendering provider (specialist and/or facility) to submit a TAR to Partnership for review. See policy MCUP3041 TAR Review Process.

L. Monitoring Referrals
   1. Partnership monitors referrals to specialists, including open or unused referrals, using data from Partnership's electronic referral system and claims. This information is submitted to the Internal Quality Improvement (IQI) Committee at least annually or more often as needed.
   2. Partnership audits the referral completion rate for a subset of high volume. This becomes part of the annual report of their referral completion rate which is reviewed by the Quality/ Utilization Advisory Committee (QUAC) and by the IQI Committee.

VII. REFERENCES:
A. InterQual® Criteria
B. Medi-Cal Guidelines
C. Welfare and Institutions Code (WIC) 14197.04

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: RAF Procedure [UM-1]: 12/27/95; 05/27/99; (TAR/RAF [UP100341] - 06/21/00; 04/18/01; 03/20/02, 05/21/03 attachments revised 10/01/03; 04/21/04; 01/19/05; 04/20/05; 09/21/05, 10/18/06, 08/20/08, 07/15/09; 5/19/10; 07/20/11, 08/21/13; 03/19/14; 04/15/15; 09/16/15; 06/15/16; 04/19/17; 09/20/17; *11/14/18; 02/12/20; 09/09/20; 02/10/21; 03/09/22; 03/08/23; 04/10/24; 04/09/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.