

VCHCP's Referrals and Prior Authorization Process



VCHCP utilizes different types of referrals for VCHCP Members:

- Direct Referral
- Direct Specialty Referral
- Standing Referral
- Prior Authorization

Appropriate medical information should be sent to all consulting providers and to the Health Plan for referrals requiring prior authorization. Examples of medical information:

- Medical history related to the diagnosis
- Results of any diagnostic tests previously performed (including lab and radiology reports)
- Consultation reports related to the diagnosis from other physicians
- Information on referrals pending for other providers

Direct Referrals

No notification to or Authorization by VCHCP is required when the following services are ordered by the Member's Primary Care Physician (PCP) and provided by an appropriately contracted Provider (for current contracted providers, check Provider Directory, also on VCHCP's web site):

- Most radiological imaging studies
- Plain x-ray, ultrasound, screening mammogram
- All radiological imaging studies at VCMC **except** Bone Scan, CT Angiography, Dexa Scan, MRI/MRA/MRV, Myelogram, PET Scan, Tagged White/Red Cell Scan, VQ Scan. Some radiologic imaging studies at non VCMC contracted facilities require prior authorization (see attached List of Diagnostic Studies that may or may not require Prior Authorization)

Direct Specialty Referrals

Direct Specialty referral allows Primary Care Physicians to directly refer members to certain specialty providers for an initial consult and appropriate follow up visits without requiring prior authorization from the Health Plan as long as the member has seen the specialist within a year for the original problem. If the member has not seen the specialist for a year, a new direct specialty referral form will be required from the primary care physician.

Direct Specialty Referral- for VCHCP members MUST be referred by the Primary Care Provider. In addition, urgent care and Emergency Room (ER) physicians may directly refer members to orthopedic specialty for urgently required consultation.

Neurologists can directly refer to Pain Management Specialists, Physiatrists [Physical Medicine and Rehabilitation Specialists (PM&R)] and Orthopedics. Pain Management Specialists and Physiatrists (PM&R) can directly refer to Orthopedics. Pain Management Specialists and Physiatrist (PM&R) can refer back and forth based on the type of referral and access. Pain Management Specialists and Physical Medicine and Rehabilitation Specialists (PM&R) can directly refer members for pain

management injections to Santa Paula Hospital Interventional Radiology.

Direct specialty referral applies to - All VCHCP contracted specialists can be directly referred by PCPs using the direct referral form [EXCLUDING TERTIARY REFERRALS, (e.g. UCLA AND CHLA), PERINATOLOGY and OFFICE PROCEDURES FOR PAIN MANAGEMENT SPECIALISTS]. Referrals to Physical Therapy and Occupational Therapy also use this form.

Selected office Procedures and Services are included in the Direct Referrals and do not require prior authorization. Procedures outside of this require prior authorization.

Direct referrals to Physical Therapy and Occupational Therapy (PT or OT) will be allowed for an initial evaluation and an additional seven (7) visits up to a total of eight (8) visits.

For PT providers only: Additional 16 physical therapy visits beyond the initial eight (8) direct referral visits will **NO LONGER** require prior authorization. Requests for additional therapy beyond the 24 visits will require prior authorization with a submission of a TAR form including the initial therapy evaluation and treatment notes.

For OT providers only: Additional 16 occupational therapy visits beyond the initial eight (8) direct referral visits will **NO LONGER** require prior authorization. Requests for additional therapy beyond the 24 visits will require prior authorization with a submission of a TAR form including the initial therapy evaluation and treatment notes.

In addition, nutritional counseling may be directly referred.

In addition to primary care physicians, direct referral for physical therapy can be made by the following specialist: Orthopedics, Rheumatology, Neurosurgery, Neurology, Podiatry, Physiatry (physical medicine and rehabilitation) and Pain Management. Once the Health Plan authorizes a Hand/Plastic Surgery specialist to see VCHCP members, the Hand/Plastic Surgery Specialist may directly refer members to physical therapy and to occupational therapy.

VCMC Referral Process: Many specialists on the panel of the Plan are specialists in the Ventura County Medical Center (VCMC) medical clinics and affiliated clinics and new appointments for them are made through the VCMC Referral Center. Those specialties are Endocrinology, ENT, Neurology, Rheumatology, Pulmonology and Neurosurgery. For a referral to any of the VCMC specialists in these specialties, the direct referral form should be sent to the VCMC Referral Office via fax or e-Referral system. The fax number is 805-677-5263.

For more details on Direct Specialty Referral, please go to the Plan's website:

www.vchealthcareplan.org

Standing Referrals

VCHCP (The Plan) supports and promotes the provision of standing referrals for members with certain chronic conditions or diseases, including but not limited to HIV and AIDS that require specialized ongoing care. Primary Care Physicians are able to request:

- Standing referrals to a specialist for members requiring continuing specialty care over a prolonged period of time, and
- Extended access to a specialist for an enrollee who has a life threatening, degenerative, or disabling condition that requires coordination of primary care by a Specialty Care Physician (SCP). The SCP is designated to serve as the coordinator of an enrollee's care.

VCHCP supports the development and use of treatment plans to be used in conjunction with the above standing referrals. This treatment plan should be requested using the plan's Treatment Authorization Request (TAR) form if deemed to be medically necessary by the member's PCP and SCP in question.

Treatment plans must describe the course of care. After receiving standing referral approval, the specialist is authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the PCP. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, VCHCP will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria. [Ref.: CA Health & Safety Code 1374.16(g)].

If VCHCP does not have an identified HIV/AIDS specialist, the member will be referred to contracted tertiary providers. Determinations based on medical appropriateness are only made by a physician holding an unrestricted license in the State of California. Requests for authorization for standing referrals to specialist are reviewed and the decisions and notifications must be made within the time frames appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed 3 working days of the date after all necessary information is received. [CA Health & Safety Code 1374.16(c)].

PROCEDURE

I. Specialty Referrals

1. Requests for standing referrals will be made either by the member's PCP, SCP or the member.
2. The request will be reviewed and agreed to by the PCP and SCP and submitted to the Plan
3. Standing referral requests include:
 - Member diagnosis
 - Required treatment
 - Requested frequency and time period.
 - Relevant medical records
4. Extended Access to Specialty Care
 - The member's PCP or SCP will make request for extended access to specialty care in which the SCP will coordinate the member's primary care.
 - Requests will indicate life threatening, degenerative, or disabling factors involved in the request.
 - Requests will be reviewed and agreed to by both the PCP and SCP and submitted to VCHCP.
 - The requesting PCP or SCP will indicate the health care services the SCP will be managing and detail those that will be managed by the PCP.

II. Extended Specialty Access Guidelines by Medical Category and Condition

VCHCP provides the PCPs and SPCs the following:

- Process for submission of Standing or Extended Specialist Referral Request to VCHCP. The Treatment Authorization Request Form (TAR) will include the language informing the SPCs of the option to request for a standing referral if they are caring for members who need continuing care and who require care over a prolonged period of time. Additionally, the TAR will contain the information on the timeframe for the length of authorization of standing referrals which is 180 days (see TAR form).
- The Plan's authorization letter will include the 180 days' timeframe authorization for standing referrals.
- VCHCP will educate primary care and specialty physicians with regards to AB 1181 and the internal policies and procedures in place to ensure compliance with

this legislation.

Services Requiring Prior Authorization

The services listed in the VCHCP Prior Authorization Guide require prior Authorization by VCHCP, unless provided on an emergency basis. **These services should not be scheduled until final notification of approval is received from the Plan.** The Plan reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the Authorization request.

Routine prospective review (prior Authorization) is the process of reviewing elective surgeries, referrals, and ancillary services to evaluate the medical necessity, appropriateness, and benefit coverage of the requested procedure. In the course of the Authorization review process, the Plan's UM staff uses a wide range of approved criteria, guidelines, and reference tools to assist in the review of medical appropriateness. These include but are not limited to the following resources:

- Milliman Care Guidelines
- U.S. Department of Health and Human Services clinical practice guidelines
- CMS Medicare Program Guidelines
- VCHCP Medical/Drug policies
- Up to Date
- CDC- Centers for Disease Control
- ACIP- Advisory Committee on Immunization Practices

Requests for prior Authorization must be received from the PCP and/or Specialists on a VCHCP Prior Authorization Request form (available on this web site) and be accompanied by all pertinent medical records. Final decision may be delayed if the supporting documents are not provided with the prior authorization request.

Submit Prior Authorization Requests to:

VCHCP Attn: UM Department 2220 E. Gonzales Rd. Suite 210B, Oxnard, CA 93036

FAX to: (805) 658-4556 For urgent requests, call: (805) 981-5060

Prior Authorization Review Timelines

VCHCP provides decisions on prior authorization requests in a prompt and timely manner appropriate for the nature of the enrollee's condition. Decisions for routine requests are not to exceed **five business days** from the Plan's receipt of request when all necessary information to make a decision is submitted with the request. Decisions for **Urgent requests are made within 72 hours from the receipt of request.** If approved, a faxed Authorization number is issued. By appropriately identifying referrals as urgent or emergent, the PCP or Specialist allows the Plan's UM staff to review these in a timely manner. Any services rendered after hours or on weekends, when the UM staff is not available, are subject to retrospective review.

Timelines for Decisions:

The Plan processes requests for prescriptions according to the following timelines:

- For new prescriptions: Within 24 hours of the Plan's receipt of the request.

- For all exigent circumstances (step therapy & formulary exception requests): Within 24 hours of the Plan's receipt of the request.
- For urgent refills: Within 24 hours of the Plan's receipt of the request.
- For other refills: Within 24 hours of the Plan's receipt of the request.
- For non- urgent prior authorization, step therapy and formulary exception requests, the Plan responds within 72 hours of the Plan's receipt of the request.

Pended Requests

- **When UM clinical staff identifies that additional information is needed to complete a TAR determination, a pend letter will be sent to the requesting provider and the member for whom the TAR is being requested indicating that the TAR has been pended.** The pend letter will specifically identify the additional information needed to make the TAR determination and provide up to 45 calendar days (for routine TAR requests) for the information to be submitted to VCHCP. **A TAR request can only be pended once**, so another request for information **will not be sent** to the requesting provider. **VCHCP does not send reminders.**
- **When the information is submitted within 45 days, then a final determination will be made within 5 business days for routine TAR requests.** Notification will be sent to the requesting provider within 24 hours of the decision and to the member within 2 business days of the decision.
- **If the information is not submitted within 45 days, then a final determination will be made based on the initial information submitted and can be denied by the VCHCP Medical Director.** Notification to the requesting provider within 24 hours of the decision and to the member within 2 business days of the decision for routine TAR requests.
- **Note that the above timeframes will apply in most situations.** There may be some variance with urgent and retrospective TAR requests. Please see the **VCHCP TAR Form** for additional timeline descriptions.

Definition:

Urgent Service/Care Requests means prompt medical services are provided in a non-emergency situation. Examples of urgent care conditions include sore throats, ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be Emergency Medical Conditions.

Urgently Needed Care/Service Requests means any otherwise Covered Service necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see his or her PCP. This includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her Provider.

Emergency/STAT Care/Requests means any otherwise Covered Service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger).
- His or her bodily functions, organs, or parts would become seriously damaged.
- His or her bodily organs or parts would seriously malfunction.

For Emergency/STAT requests, please send the member to the appropriate provider or call 911. Please call VCHCP UM Department if referral assistance is needed, such as identifying a provider.

Emergency Care includes paramedic, ambulance and ambulance transport services provided through the “911” emergency response system.

Emergency Care also includes the treatment of severe pain or active labor.

Emergency Care also includes additional screening examination and evaluation by a Physician (or other health care Provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capacity of the facility.

Notification

The Health Plan notifies the providers (PCP, Specialist, Facilities whichever is applicable) via fax of the decision of their Treatment Authorization Request (TAR) within 24 hours of decision for routine requests and for urgent requests. The Health Plan sends approval or denial notification letters to the members via mail regarding the decision of the authorization request within 2 business days of the decision. If the service was denied, the denial letter includes a clear and concise explanation of the reason for denial and a description of the criteria used to deny the request. All letters of denial include a description of how to file an appeal. The returned authorization/decision/TAR form specifies the service authorized, number of treatments, valid from and to dates, and expected length of stay (if appropriate). For questions regarding the status of a prior Authorization request, contact VCHCP by phone at (805) 981-5060.

A. Review & Revision History:

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Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/9/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review; updated with the expansion of the direct referral specialties and DMHC UM review timeframe requirements.
2/8/18	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
5/3/18	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Added: Emergency Room (ER) physicians may now directly refer members to Orthopedics specialty for urgently required consultation.
5/29/18	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Added nutritional counseling to direct referral.
10/11/18	Yes	Robert Sterling, MD, Faustine Dela Cruz, RN	Effective 1/1/19, updated - exclusion for direct referral to contracted Non-VCMC Pain Specialists to office procedures ONLY. Office visits to contracted Non-VCMC Pain Specialists can be directly referred by PCPs.
10/11/18	Yes	Robert Sterling, MD, Faustine Dela Cruz, RN	Effective 1/1/19 For PT providers only: Additional 16 physical therapy visits beyond the initial eight (8) direct referral visits will NO LONGER require prior authorization. Requests for additional therapy beyond the 24 visits will require prior authorization with a submission of a TAR form including the initial therapy evaluation and treatment notes. For OT providers only: Additional 16 occupational therapy visits beyond the initial eight (8) direct referral visits will NO LONGER require prior authorization. Requests for additional therapy beyond the 24 visits will require prior authorization with a submission of a TAR form including the initial therapy evaluation and treatment notes.
2/14/19	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
5/9/19	Yes	Robert Sterling, MD, Faustine Dela Cruz, RN Meriza Ducay, RN	Updated with DMHC timeliness standards for prescription medications.
2/13/20	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/11/21	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review

2/17/22	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
11/10/22	Yes	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Contracted Non-VCMC pain management specialists no longer requires prior authorization for pain management office visits
2/2/23	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/8/24	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review