	Referrals	UM-002
Department	Health Services	
Functional Area	Utilization Management	
Line of Business	☒ Medi-Cal ☒ D-SNP	

DELEGATION OF FUNCTION		
☒ Health Net	☒ Community Care IPA	☐ Not Delegated
☒ Community Health Group	☒ Primary Healthcare Medical Group	
☒ Imperial County Physicians MG	☒ Premier Patient Care	

DATES			
Policy Effective Date	06/12/2023	**Reviewed/Revised Date**	12/11/2025
Next Annual Review Due	12/11/2026	**Regulator Approval**	12/15/2024

APPROVALS			
Internal		**Regulator**	
Name	Gordon Arakawa, MD	☐ DHCS	☐ NA
Title	Chief Medical Officer	☒ DMHC	

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Title 42 Code of Federal Regulations (“CFR”) 1369d (r)(5), 438.298(c)(4)
  - Federal Public Health Service Act Section 2719 (42 U.S.C. Sec. 300gg-19)
- **State**
  - California Health and Safety Code Sections (“H&S Code”) 1363.5, 1367.01, 1373.96, 1374.16
  - Welfare and Institutions Code Sections (“W&I Code”) 14182(b)(13) and (14), 14450.5
  - Title 22 California Code of Regulations Rules (“CCR”) 51340, 51340.1, 51014.2, 53894
  - Title 28 CCR Rules 1300.67.2.2, 1300.70(b)(2)(H) and (c), 1300.74.16
  - 2024 DHCS Contract Exhibit A, Attachment III, Section 2.3 Utilization Management Program
  - DHCS APL 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care

HISTORY

Revision Date	Description of Revision
06/12/2023	Policy creation
10/01/2024	Annual review- no changes
12/11/2025	Updates to procedure section

I. OVERVIEW

A. This policy addresses Community Health CHPIV of Imperial Valley's ("CHPIV" or the "CHPIV") Provider Referrals requirements, policy, and procedures. The purpose of this policy is to establish a comprehensive STANDING REFERRAL process.

II. POLICY

A. CHPIV shall maintain a STANDING REFERRAL process that provides a determination within four Working Days from the date the request is made by the MEMBER or the MEMBER's PRIMARY CARE PROVIDERS (PCP) and all appropriate medical records and other items of information necessary to make the determination are provided.
   1. Once a determination is made, the referral must be made within four Working Days of the date that the proposed treatment plan, if any, is submitted to the medical director or the medical director's designee.

B. CHPIV shall maintain a STANDING REFERRAL process for SPECIALISTS.
   1. CHPIV shall provide a STANDING REFERRAL to a SPECIALIST if the PCP determines, in consultation with the SPECIALIST and plan medical director or designee, that an enrollee needs continuing care from a SPECIALIST.
      a. The referral shall be made pursuant to an approved treatment plan in consultation with the plan, PCP, the SPECIALIST, and the MEMBER, if a treatment plan is deemed necessary to describe the course of the care.
      b. A treatment plan may be deemed to be not necessary provided that a current STANDING REFERRAL to a SPECIALIST is approved by CHPIV or any of its SUBCONTRACTORS.
      c. The treatment plan may limit the number of visits to the SPECIALIST, limit the period that the visits are authorized, or require that the SPECIALIST provide the PCP with regular reports on the health care provided to the MEMBER.

C. CHPIV provides a MEMBER with a condition or disease that requires specialized medical care over a prolonged period and is life-threatening, degenerative, or disabling a referral to a SPECIALIST or Specialty Care Center that has expertise in treating the condition or disease.
   1. The referral shall be made if the PCP, in consultation with the SPECIALIST or Specialty Care Center if any, and plan medical director or designee determines that this specialized medical care is MEDICALLY NECESSARY for the MEMBER.
   2. The referral shall be made pursuant to a treatment plan approved by the plan in consultation with the PCP, SPECIALIST or Specialty Care Center, and MEMBER, if a treatment plan is deemed necessary to describe the course of care.
   3. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a SPECIALIST or Specialty Care Center is approved by CHPIV or any of its SUBCONTRACTORS.
      a. After the referral is made, the SPECIALIST shall be 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, subject to the terms of the treatment plan.

D. CHPIV shall disclose or provide the policies, procedures, and the description of the process for STANDING REFERRALS to MEMBERS, Network Providers and/or SUBCONTRACTORS.

E. CHPIV's Quality Assurance Programs shall ensure an oversight mechanism in place will detect and correct any under-service, as determined by patient-mix for an at-risk provider, including possible underutilization of specialist services and preventive health care services.
    1. CHPIV shall design and implement reasonable procedures for continuously reviewing the performance of all health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the DHCS.

F. When the MEMBER's condition is such that the MEMBER faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the MEMBER, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, however:
    1. Decisions shall be made in a timely fashion appropriate for the nature of the MEMBER's condition, not to exceed 72 hours or, if shorter, the period of time required, after receipt of the information reasonably necessary and requested by the plan to make the determination.
        a. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

G. CHPIV shall work with an approved out-of-network provider and its contracted network and must not refer the MEMBER to another out-of-network provider without authorization from CHPIV. In such cases, CHPIV will make the referral, if MEDICALLY NECESSARY, if CHPIV does not have an appropriate provider within its network.

III. PROCEDURE

A. Delegation of Functions
    1. Delegated functions covered under this policy are described in the applicable delegate's own policies and procedures governing the performance of those functions. Delegates are required to maintain compliant and current policies consistent with applicable regulatory and contractual requirements. CHPIV's oversight activities verify adherence to those standards.

B. Delegation Oversight
    1. CHPIV maintains full accountability for all delegated activities and provides oversight to ensure compliance with federal, state, and contractual requirements.
    2. Oversight activities are conducted in accordance with CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure, and include:
        a. Ongoing monitoring
        b. Performance reviews
        c. Data analysis
        d. Utilization of benchmarks, if available
        e. Annual desktop and on-site audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Medically Necessary/Medical Necessity	Means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I Code sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by- case basis, considering the individual needs of the child
Network Provider	Means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
Primary Care Provider (PCP)	Means a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For SPD Members, a PCP may also be a Specialist or clinic.
Prior Authorization	Means a formal process requiring a Provider to obtain advance approval the amount, duration, and scope of non-emergent Covered Services.
Provider	Means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Specialist	Means a Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in W&I Code section 14197.
Standing Referral	Means a referral by a PCP to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the Primary Care Provider having to provide a specific referral for each visit.
Subcontractor	Means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract.