	POLICIES AND PROCEDURES
Policy #: HS 3.91	Lead Department: Health Services
Title: Authorization Process for Referrals to Out of Area Providers	
Original Date: June 2008	Last Revision Date:
Approved by: UM Work Group, Richard Helmer, MD	
Applies to: All Lines of Business	


I. Purpose:

To describe the Alliance authorization process for referrals to out of area providers.

II. Definitions:

For the purpose of this policy and procedure, the following definitions of key terms are outlined below:

- Authorization – A process by which the Alliance reviews and determines appropriateness of a provider request for pre (prior to), concurrent (at the time of) or retroactive (after) service of a covered benefit(s) as described in Alliance Health Services Authorization Policies, Section 3.2. Authorization is required for services including elective inpatient procedures, MRIs, PET scans and other complex procedures as defined by Alliance authorization list as defined in the Provider Manual. Authorization should always be prior to services being rendered, except when there are extenuating circumstances such as when eligibility is granted retroactively. A provider request for authorization is submitted using a treatment authorization form (TAR).
- Authorization for referral to services provided out of area – Via the submission of a TAR, a referring primary care physician (PCP) or contracted physician, requests Alliance review and determination of appropriateness to refer a member to an out of area provider for specific outpatient services (e.g. consultation, office-based visit or procedure, routine labs, stress tests), and that do not require additional authorization via a TAR.
- Out of Area Provider – Any provider not based in the plan’s service area (Monterey and Santa Cruz Counties), regardless of Alliance/provider contract status.
- Referral to services provided out of area - The process by which a primary care physician (PCP) or contracted physician refers a member to an out of area provider for specific outpatient or inpatient services. A referral to an out of area provider requires review and authorization by the Alliance. A referral to an in area provider does not require a TAR, or review and authorization by the Alliance, though health plan staff screen for “carved out” services and retain the right to redirect either the member or the provider.
- Treatment Authorization Request (TAR) – An Alliance form completed and submitted by a provider to request review and approval for out of area services and / or treatment to be provided to a member.

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III. Policy:

It is Alliance policy to review referrals to out of area providers regardless of contract status, prior to any Alliance authorization, to ensure medical criteria is met and that the member is referred to an appropriate provider.

General indications for referrals to out of area providers include:

1. A procedure or other service that is not available through an in area provider.
2. Consultation expertise beyond what is available through an in area provider.
3. Complexity of member's medical needs (i.e. age, co-morbidity), requires service out of area.

IV. Process:


TAR submission:

The PCP, or other provider, requesting referral to an out of area provider is required to complete a TAR, and submit it by fax to the Alliance Utilization Management Department. Completion of the TAR for out of area referral purposes is not required to be expressed at the procedure code level and can be more general (i.e. consultation, work-up, office-based procedures).

Initial review:

Initial review is performed by the referral staff (coordinator/nurse) against the following criteria:

- 1) Determine if this is a service that can be provided within the area.
- 2) If so, determine if the referring provider has attempted to refer within Santa Cruz and Monterey Counties and was unable to establish access. If so, refer to the Medical Director or Associate Medical Director for a final determination. Notify the Provider Services Department regarding any access issues.
- 3) Determine if this referral is to a provider that has a contract with the Alliance. If not, determine whether it can be re-directed to a contracted provider. If not, and the non-contracted provider is the only option (and the referral meets all other criteria), refer to the Finance department for possible negotiation of a contract.
- 4) Determine if there is potential coordination of benefits (COB) or other coverage. Potential emphasis should be placed on:

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- a) CCS for members (especially Medi-Cal under the age of 21 or Healthy Families/Healthy Kids members under the age of 18).
- b) Medicare (especially referrals for end stage renal disease or ESRD and renal transplants). If the member does not have Medicare, determine if they are eligible. In these cases, referrals should be made to the appropriate agencies.
- c) Veterans Administration (VA) – Determine if the member is eligible and whether or not they have been getting care under the VA system.

Clinical review of services:

Services requested will be reviewed for clinical appropriateness. This will be undertaken by a nurse with input from either the Medical Director or Associate Medical Director.

Examples include:

1. For specialty consultation for complex cases, was the member seen by an in area specialist and the specific areas of concern and/or appropriateness determined about the facility the member was referred to?
2. Has appropriate evaluation been undertaken in area, including diagnostic studies?
3. Was the request made due to age restrictions (infants or children)? Ensure that is the case with the in area provider of the services.
4. Does the member meet the general criteria, with no contra-indications, for transplants, weight reduction procedure evaluations or other complex procedures?

All aspects of Alliance Authorization process for Out of Area review will adhere to Alliance Health Services Authorization Policies as described in HS Policies and Procedures Section 3.2, including but not limited to authorization timeliness, approvals, denials, notification, etc.