Physician Services: Primary Care and Specialist Visits

Policy Number: BIP131.M
Effective Date: May 1, 2024

➲ Instructions for Use

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Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

California Health and Safety Code, Division 2, Licensing Provisions, Chapter 2.2 Health Care Service Plans, Article 5., 1374.16

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1374.16.

(a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. 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 the plan or its contracting provider, medical group, or independent practice association. 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 enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a

determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.

(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).

(e) For the purposes of this section, "specialty care center" means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(f) As used in this section, a "standing referral" means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

California Health and Safety Code Section 1367.69

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.69.

(a) On or after January 1, 1995, every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state, shall include obstetrician-gynecologists as eligible primary care physicians, provided they meet the plan's eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, the term "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including but not limited to preventive services, acute and chronic conditions, and psychosocial issues.

Direct Access to OB-GYN (California Health and Safety Code Section 1367.695)

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.695.

(a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Each health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a health care service plan may establish reasonable requirements, governing utilization protocols and the use of obstetricians and gynecologists, or practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, if those requirements are consistent with the intent of this section and are customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and are no more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for follow up care.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

- Physician Care (Primary Care Physician, Provider and Specialist): Diagnostic, consultation and treatment services provided by the Member's Primary Care Physician (PCP) are covered. Physician/Practitioner Services (including network consultant and, where necessary, referral services by a Physician) provided by a licensed Physician/Practitioner within the Network Medical Group (Refer to the Benefit Interpretation Policy titled Emergency and Urgent Services).
- Services of a Specialist are covered upon referral by the Member's Network Medical Group or UnitedHealthcare. A Specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
- Examples of covered benefits include but are not limited to:
  - Consultation by a second Physician at the request of the member and/or attending Provider, which includes a written report of the history and physical of the member. (Refer to the Benefit Interpretation Policy titled Member Initiated Second and Third Opinion).
  - Preventive health examinations (Refer to the Benefit Interpretation Policy titled Preventive Care Services).
  - Establishment and implementation of an appropriate treatment plan by the Primary Care Physician in consultation with the Specialist for members with complex or serious medical conditions, with an adequate number of access visits to Specialists to accommodate the treatment plan.
  - Coumadin (anti-coagulation) monitoring performed at a free-standing clinic or a clinic within a hospital or that is attached to a hospital when referred and authorized by the member's Primary Care Physician, Primary Medical Group, or IPA.
    Note: A PCP office visit copayment may be assessed by the Doctor of Pharmacy (PharmD) at the Coumadin clinic when the PharmD is (1) licensed by the state and is performing within the scope of practice **and** (2) performing under the direct supervision of an M.D. or D.O.
  - Specialists and/or consultants requested by emergency room personnel as a result of emergency treatment. (Refer to the Benefit Interpretation Policy titled Emergency and Urgent Services).
  - Specialists and/or consultants regardless of HMO affiliation when the Network Medical Group has no contracted Specialists, or the contracted Specialist is not available at the time services are necessary.
- Treatment by other Non-Physician Health Care Practitioners, such as acupuncturists and chiropractors may be available if purchased as a supplemental benefit.
  Note: As part of EHB: California Small Groups: Acupuncture services are covered under the medical benefits. Refer to the Benefit Interpretation Policy titled Complementary and Alternative Medicine for additional information.

Not Covered

- Treatment for any illness or injury provided by someone other than a licensed Physician, surgeon, or healthcare professional.
- Employer requests for clearance to work or documentation as a reason for missed work.
- Services that are oriented toward treating a social, developmental or learning problem as opposed to a medical problem with the exception of covered rehabilitative and habilitative services. Refer to the Benefit Interpretation Policies titled Habilitative Services and Rehabilitation Services (Physical, Occupational, and Speech Therapy) for additional information.
- Completion of forms, e.g., insurance, employment, school, sports, summer camp, Department of Motor Vehicle (DMV), etc.
- Services for:
  - Members that are engaged in active military duty.
  - Any service required by an employer or conditions covered by Workers Compensation unless mandated by the state in the Federal/State Mandated Regulations section.

Note: Refer to member's EOC.

Policy History/Revision Information

Date	Summary of Changes
01/01/2025	**Template Update** • Modified font style; no change to policy content

05/01/2024	**Related Policies**
	• Added reference link to the Benefit Interpretation Policy titled:
	  ○ *Complementary and Alternative Medicine*
	  ○ *Habilitative Services*
	  ○ *Member Initiated Second and Third Opinion*

Date	Summary of Changes
	○ *Rehabilitation Services (Physical, Occupational, and Speech Therapy* **Supporting Information** • Removed *Definitions* section • Archived previous policy version BIP131.L

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.