SAN FRANCISCO HEALTH PLAN
Here for you

Policy and Procedure

Policy Name:	Referrals, Consults, and Diagnostic Studies		
Effective Date:		Revision Date:	
Department(s)/Site(s):			
Document Owners:			
Approved By:			
Relevant Law/Standard:	Department of Health Care Services (DHCS) All Plan Letter 20-006, Site Reviews: Facility Site Review and Medical Record Review or any superseding APL		

Purpose:

There is evidence of practitioner review of referrals, consults, and diagnostic tests.

Definitions:

Consultation: A consultation is a request from one physician to another for an advisory opinion. The consultant performs the requested service and makes written recommendations regarding diagnosis and treatment to the requesting physician. The requesting physician utilizes the consultant's opinion combined with his own professional judgment and other considerations (e.g. patient preferences, other consultations, family concerns, and comorbidities) to provide treatment for the patient. (https://aafp.org)

Referral: A referral is a request from one physician to another to assume responsibility for management of one or more of a patient's specified problems. This may be for a specified period of time, until the problem(s) is resolved, or on an ongoing basis. This represents a temporary or partial transfer of care to another physician for a particular condition. It is the responsibility of the physician accepting the referral to maintain appropriate and timely communication with the referring physician and to seek approval from the referring physician for treating or referring the patient for any other condition that is not part of the original referral.(https://aafp.org)

Policy and Procedure:

A. It is the policy of _____ to ensure a collaborative approach to care through the coordination of care, treatment and community-based services based on the patient's needs. This policy applies to all internal and external referrals. This includes but is not limited to specialty care, ancillary services, dental, mental health and substance abuse, self-management support, health education, and health promotion.
B. Electronically maintained medical reports must also show evidence of practitioner review, and may differ from site to site.

C. Evidence of practitioner review on any page of the report(s) or diagnostic result(s) that have multiple pages is acceptable.
D. There is evidence of practitioner review of consult/referral reports and diagnostic test results.
    a. There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports.
    b. Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review.
E. There is evidence of follow-up of specialty referrals made, and results/reports of diagnostic tests, when appropriate.
    a. Consultation reports and diagnostic test results are documented for ordered requests.
    b. Abnormal test results/diagnostic reports have explicit notation in the medical record or separate system, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information.
    c. Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions.
    d. If diagnostic appointments or referrals are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements.

_____ _____

First Name Last Name – Title Date

_____ _____

First Name Last Name – Title Date

Referral Log

Date Referral sent to IPA	Patient Name and/or Medical Record Number	Referred to: Specialist/ Facility	Auth. Status & Date Approved/ Denied/ Deferred	Date Patient notified	Date of Appt / Services	DATE REPORT RECEIVED AND/OR COMMENTS

*Acuity of Referral: Emergent, Urgent or Routine

Abnormal Results Contact Attempt Record

Please note: All attempts to contact a patient must be recorded in the patient's individual medical record at the time of the contact. This is a legal safeguard. Practice staff **MUST NOT** give out test results to patients unless expressly advised to by the PCP.

Patient's Name				
DOB				
Patient's Physical Initials				
Urgency of consult				
Type of test, e.g. blood, pap				
Time, date, phone no. & staff initials of 1st phone call				
Time, date, phone no. & staff initials of 2nd phone call				
Time, date, phone no. & staff initials of 3rd phone call				
Date 1st letter sent				
Mail returned?				
Date 2nd letter sent				
Mail returned?				
Date Registered Mail Sent				
Post office confirmation received receipt				