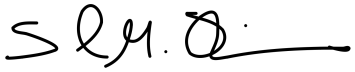
Elite Health Plan **POLICY AND PROCEDURE**	Elite Health MEDICARE ADVANTAGE
Name: Elite Health Plan Policy for Tertiary Care Requests	Policy Number: **UM-MED-27**
Department: Utilization Management Department	Effective Date: 01/01/2027 Date Revised: 11/17/2026 Date Reviewed: 11/18/2026
Reviewed and Accepted By: Sunil Shivaram, M.D. Sri Gorty, M.D., Kristina Fletcher UM Manager	**Chief Medical Officer Signature:**  Page 1 of 6

PURPOSE:

The purpose of this policy is to establish standardized criteria for the review, approval, redirection, and notification of requests involving tertiary care providers and facilities. This policy ensures that Elite Health Plan members receive medically necessary covered services in the most clinically appropriate setting and level of care while maintaining timely access, quality outcomes, cost-effective utilization of healthcare resources, and compliance with applicable federal and state regulatory requirements.

This policy also provides guidance for determining when tertiary care services are warranted, when redirection to a qualified contracted community provider or facility is appropriate, and when adverse determination notices must be issued when a requested provider or facility is not approved.

SCOPE:

This policy applies to the CMS Medicare Advantage Prescription Drug (MAPD) Program and addresses the requirements and processes related to delegated Utilization Management (UM) functions assigned by Independent Practice Associations (IPAs) or other contracted entities. Applicable personnel in Elite Health Plan, Inc, Delegated IPAs and Medical Groups follow this policy. This document is intended to describe processes necessary to meet regulatory requirements as of the effective date above.

DEFINITIONS:

Term	Description
CMS	Centers for Medicare and Medicaid Services – The agency within the US Federal Government that is charged with the execution and maintenance of the law definingthe prescription drug program for senior citizens, the disabled, and the infirm.
MA	Medicare Advantage
Concurrent review decision	Extension of previously approved ongoing treatment, typically inpatient or ambulatory care.
Contracted Provider	A healthcare provider or vendor with an active agreement with Elite Health Plan.
Supplemental Benefit	A benefit offered by Elite Health Plan that is not covered under Original Medicare.
EOC	Evidence of Coverage
Medically Necessary	Services or supplies that are reasonable and necessary for the diagnosis or treatment of illness or injury and meet accepted standards of medical practice.
Tertiary Care	Tertiary care is specialized consultative medical care provided by specialists in centers that possess personnel, equipment, and facilities required for advanced diagnostic evaluation and treatment of complex medical conditions. Tertiary care centers frequently include academic medical centers, teaching hospitals, specialty hospitals, and centers with specialized technologies and subspecialty expertise unavailable in general community hospitals. [Examples include Comprehensive cancer centers, Organ transplant centers, Academic medical centers]
Community-Based Specialist	A contracted specialist practicing within the Health Plan service area who is qualified to provide equivalent medically necessary services in an outpatient, office-based, ambulatory, or community hospital setting.

POLICY:

If Elite Health Plan (EHP) or its delegated provider network is unable to provide medically necessary services within the contracted provider network, the Primary Care Provider (PCP) or treating specialist may request referral authorization to a tertiary care practitioner or facility.

Requests for tertiary care services shall be reviewed by the Utilization Management Department and, when applicable, the Medical Director or designee to determine medical necessity and whether the requested services require tertiary-level expertise, resources, technology, or multidisciplinary care not otherwise available within the contracted network.

When medical necessity is established and the required service cannot be provided within the Elite Health Plan contracted network by a provider with appropriate clinical expertise and access, the referral shall be approved as medically indicated.

Elite Health Plan Considers the Following Referrals to Tertiary Care Centers Medically Necessary

1. Specialized Diagnostic Evaluation, Treatment, or Procedures

Referrals generated by community-based specialists documenting a medical need for a higher level of care due to specialized diagnostic approaches, advanced treatments, specialized procedures, multidisciplinary management, or subspecialty expertise not available within the community network.

2. Continuity of Care

Referrals that meet applicable federal or state continuity of care requirements, including situations in which:

- The member is actively receiving treatment for an acute or serious medical condition;
- Continuity of treatment is necessary to prevent interruption in care;
- The member has been evaluated or treated by the tertiary care provider within the previous twelve (12) months; and
- The provider agrees to accept applicable Health Plan reimbursement rates and has no documented quality-of-care concerns.

3. Prevention of Delayed Care

Referrals for which redirection may result in delay of medically necessary treatment, diagnostic evaluation, treatment planning, surgery, or coordination of care.

Ancillary services, including radiology, laboratory studies, pathology, and diagnostic testing, shall be evaluated to determine whether redirection could reasonably delay treatment decisions or negatively affect member outcomes.

4. Related Multi-Disciplinary Specialty Care

Referrals to secondary specialties that are therapeutically related to a primary condition being actively managed at the tertiary care center and where multidisciplinary coordination contributes to the member's overall treatment plan.

Example: A member with New York Heart Association (NYHA) Class IV Congestive Heart Failure managed by a tertiary care cardiologist who also requires evaluation and treatment for pulmonary hypertension by a pulmonary specialist within the same tertiary center.

5. Limited Access or Limited Availability Specialties

Requests for specialty consultation when equivalent expertise is unavailable or has limited access within the community network.

Examples include, but are not limited to:

- Transplant Medicine
- Other highly specialized disciplines requiring tertiary-level expertise

6. Lack of Available Network Resources

Approval for tertiary care may be appropriate when:

- No contracted provider or facility is available to evaluate and treat the member's condition;
- No contracted provider possesses the required clinical expertise;
- Appropriate diagnostic or treatment equipment is unavailable within the contracted network; or
- Network access standards cannot be met.
- Maintains the clinical capabilities necessary to treat the member's condition.

REDIRECTION OF TERTIARY CARE REQUESTS

Requests Appropriate for Redirection

1. General Specialty Consultation Requests

Consultation requests when a contracted specialist meeting access standards can provide equivalent diagnostic and treatment services within the community network.

2. Ancillary Services

Requests for radiology, laboratory testing, pathology services, and other ancillary services that can be performed within the community network without causing delays in diagnosis, treatment, or care coordination.

3. Unrelated Specialty Consultations

Consultations unrelated to the primary condition for which the member is receiving care at a tertiary center and for which qualified community-based specialists are available.

4. Stable Members in the Maintenance Phase of Care

Members whose condition is clinically stable and no longer requires tertiary-level resources may be redirected to a contracted community specialist of the same discipline when:

- Ongoing treatment is routine or maintenance-based;
- Equivalent services are available;
- Appropriate access standards are met; and
- Clinical outcomes are not expected to be adversely impacted.

5. Non-Complex Hematology/Oncology Consultations

Hematology/Oncology consultations involving conditions that do not demonstrate:

- Advanced-stage disease;
- Metastatic disease;
- Rare malignancies;
- Aggressive cancer subtypes; or
- Need for tertiary-level multidisciplinary oncology services.

Circumstances in Which Redirection Is *Not* Appropriate

Redirection shall generally not occur when:

- Continuity-of-care requirements apply;
- Multidisciplinary tertiary care coordination remains medically necessary;
- Specialized equipment or expertise is required;
- Access standards cannot be met;
- Redirection would delay treatment;
- No equivalent provider is available; or
- Redirection could compromise patient safety or treatment outcomes.

Notification Requirements

When Elite Health Plan determines that the requested service is medically necessary but that the requested tertiary care provider or facility is not medically necessary because equivalent services are available through a contracted provider or facility, the Health Plan shall:

- Approve the medically necessary service at the alternative community network provider or facility;
- Issue a written adverse determination notice regarding the requested provider or facility;
- Notify the member and requesting provider of the redirection decision;
- Identify the approved alternative provider or facility; and
- Provide applicable appeal and grievance rights in accordance with federal and state requirements.

References:

1. California Health and Safety Code §1383.15.
2. National Center for Biotechnology Information, US National Library of Medicine. Tertiary Care Centers. Accessed November 17, 2026. at https://www.ncbi.nlm.nih.gov/mesh?Db=mesh&term=Tertiary+Care+Centers

Date of Revision:	Revised by:	General Revision Notes
11/17/2026	Kristina Fletcher	Implementation