Physician Services: Primary Care and Specialist Visits

Policy Number: BIP132.M
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➲ Instructions for Use

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Related Benefit Interpretation Policies

- Emergency and Urgent Services
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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.

Texas

Texas Insurance Code Chapter 1271, Section 1271.201 Designation of Specialist as Primary Care Physician

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1271&Phrases=1271.201&HighlightType=1&ExactPhrase=False&QueryText=1271.201

(a) An evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a non-primary care physician specialist as the enrollee's primary care physician.
(b) The application must:
  (1) Include information specified by the health maintenance organization, including certification of the medical need; and
  (2) Be signed by the enrollee and the nonprimary care physician specialist interested in serving as the enrollee's primary care physician.
(c) To be eligible to serve as the enrollee's primary care physician, a physician specialist must:
  (1) Meet the health maintenance organization's requirements for primary care physician participation; and
  (2) Agree to accept the responsibility to coordinate all of the enrollee's health care needs.

Washington

Washington Administrative Code (WAC) Section 284-170-200, Network Access – General Standards

https://apps.leg.wa.gov/wac/default.aspx?cite=284-170-200

(1) An issuer must maintain each provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.
(2) Each enrollee must have adequate choice among health care providers, including those providers which must be included in the network under WAC 284-170-270, and for qualified health plans and qualified stand-alone dental plans, under WAC 284-170-310.

(3) An issuer's service area must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status.
(4) An issuer must establish sufficiency and adequacy of choice of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.
(5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.

    An issuer may use facilities in neighboring service areas to satisfy a network access standard if one of the following types of facilities is not in the service area, or if the issuer can provide substantial evidence of good faith efforts on its part to contract with the facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the facility. This applies to the following types of facilities:
    (a) Tertiary hospitals;
    (b) Pediatric community hospitals;
    (c) Specialty or limited hospitals, such as burn units, rehabilitative hospitals, orthopedic hospitals, and cancer care hospitals;
    (d) Neonatal intensive care units; and
    (e) Facilities providing transplant services, including those that provide solid organ, bone marrow, and stem cell transplants.
(6) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits.
(7) A single case provider reimbursement agreement must be used only to address unique situations that typically occur out-of-network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.
(8) An issuer must disclose to enrollees that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of the issuer. A description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble to the provider directory for a health plan. In the alternative, the description of referral and authorization practices may be included in the summary of benefits and explanation of coverage for the health plan.
(9) To provide adequate choice to enrollees who are American Indians/Alaska Natives, each health issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered medical and behavioral health services provided by Indian health care providers.
    Issuers must ensure that such enrollees may obtain covered medical and behavioral health services from the Indian health care provider at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits an issuer from limiting coverage to those health services that meet issuer standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.
(10) An issuer must have a demonstrable method and contracting strategy to ensure that contracting hospitals in a plan's service area have the capacity to serve the entire enrollee population based on normal utilization.
(11) At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy. An issuer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal enrollee utilization patterns.
    (a) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers.

(b) There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders or other recognized diagnostic manual or standard.

(c) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure. The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met.

(d) Emergency mental health services, including crisis intervention and crisis stabilization services, must be included in an issuer's provider network

(e) An issuer's monitoring of network access and adequacy must be based on its classification of mental health and substance use disorder services to either primary or specialty care, ensuring that a sufficient number of providers of the required type are in its network to provide the services as classified. An issuer may use the classifications established in WAC 284-43-7020 for this element of its network assessment and monitoring.

(f) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours by using the issuer's transparency tool developed pursuant to RCW 48.43.007 and by referring to the network provider directory

(12) The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005 and WAC 284-43-5640(9) and 284-43-5642(9). If these services are provided through a quit-line or helpline, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.

(13) For the essential health benefits category of ambulatory patient services, as defined in WAC 284-43-5640(1) and 284-43-5642(1), an issuer's network is adequate if:

(a) The issuer establishes a network that affords enrollee access to urgent appointments without prior authorization within forty-eight hours, or with prior authorization, within ninety-six hours of the referring provider's referral.

(b) For primary care providers the following must be demonstrated:

(i) The ratio of primary care providers to enrollees within the issuer's service area as a whole meets or exceeds the average ratio for Washington state for the prior plan year;

(ii) The network includes such numbers and distribution that eighty percent of enrollees within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

(iii) Enrollees have access to an appointment, for other than preventive services, with a primary care provider within ten business days of requesting one.

(c) For specialists:

(i) The issuer documents the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and

(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with such a specialist within fifteen business days for nonurgent services.

(d) For preventive care services, and periodic follow-up care including but not limited to standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, the issuer permits scheduling such services in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(14) The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(a) An issuer of such stand-alone dental plans must demonstrate that, for the dental plan's defined service area, all services required under WAC 284-43-5700(3) and 284-43-5702(4), as appropriate, are available to all enrollees without unreasonable delay.

(b) Dental networks for pediatric oral services must be sufficient for the enrollee population in the service area based on expected utilization.

(15) Issuers must meet all requirements of this subsection for all provider networks. An alternate access delivery request under WAC 284-170-210 may be proposed only if:

(a) There are sufficient numbers and types of providers or facilities in the service area to meet the standards under this subchapter but the issuer is unable to contract with sufficient providers or facilities to meet the network standards in this subchapter; or
(b) An issuer's provider network has been previously approved under this section, and a provider or facility type subsequently becomes unavailable within a health plan's service area; or
(c) A county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, and the issuer chooses to propose an alternative access delivery system for that county; or
(d) A qualified health plan issuer is unable to meet the standards for inclusion of essential community providers, as provided under WAC 284-170-310(3).

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 (PCP), specialist]: diagnostic, consultation and treatment services provided by the member's 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 from 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 member's PCP 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 PCP or network medical group.
    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.
- Treatment by other non-physician health care practitioners, such as acupuncturists and chiropractors may be available if purchased as a supplemental benefit.

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	State(s) Affected	Summary of Changes
05/01/2025	All	**Covered Benefits** • Replaced reference to “primary medical group or IPA” with “network medical group” **Supporting Information** • Archived previous policy version BIP132.L
	Texas	**Federal/State Mandated Regulations** • Revised language pertaining to *Texas Insurance Code Section 1271.201*

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.