Anthem Blue Cross
Anthem Blue Cross Life and Health Insurance Company
Care Management Policy

Policy Number:	CA Care Management 04
Policy Title:	Continuity of Care, Transition of Care
Policy Approval Date:	11/00
Policy Review/Revision Date:	9/01, 04/18/02, 08/14/03, 05/15/07 Filed DMHC, 08/21/08, 08/19/10, 8/18/11, 04/5/12, 4/4/13, 5/2/13, 02/04/14 Filed DMHC, 03/06/14, 03/05/15, 03/03/16, 07/07/16, 09/14/16 Filed DMHC, 07/06/17, 12/2017 for 01/01/18 Effective Date
Products:	HMO, POS, PPO, EPO, CDHP, MCS, ASO, Fully Insured, Large Group, Small Group, Individual

Purpose:

To ensure continuity of care/transition of care (COC/TOC) for members when:

- Their Primary Medical Group (PMG), Independent Physician Association (IPA), Preferred Provider Organization (PPO) provider, or hospital is terminated from the Anthem Blue Cross participating provider network, AND
    - the member was receiving services for one of the conditions cited below in the Continuity of Care – When it is Applicable section at the time of the contract's termination, AND
    - their treating provider is not part of the Anthem Blue Cross participating provider network

- They are a newly covered enrollee to Anthem Blue Cross whose prior coverage was terminated when they were involuntarily switched to an Anthem Blue Cross plan by their employer or when their health benefit plan was withdrawn from the market, AND
    - the newly covered enrollee was receiving services from a provider who was part of their previous plan's participating provider network, for one of the conditions cited below in the Continuity of Care – When it is Applicable section at the time their coverage became effective, AND
    - their treating provider is not part of the Anthem Blue Cross participating provider network

- Continuity of care is at risk for reasons over which the member has no control.

- This policy does not apply to any newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans or providers.

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Care Management

Policy Number:	CA Care Management 04
Policy Title:	Continuity of Care, Transition Assistance

Policy:

- COC/TOC through the Transition Assistance Department allows eligible members in a course of treatment to continue otherwise covered services with non-participating providers until the course of treatment is complete or until it is safe to transition the member to a participating provider.

- The member remains responsible for any co-payments, deductibles, or other cost sharing components during the COC/TOC period at the same level as if the member was seeing a participating provider, based on the terms of their Anthem Blue Cross benefit plan.

- The length of the transition period will be determined on a case by case basis taking into consideration the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. Reasonable consideration is given to the potential clinical effect of a change of providers on the member's condition.

- Non-participating providers must agree to the same contractual terms and conditions that are imposed upon non-capitated participating providers, including, but not limited to, rates of payment.

- This policy does not apply to any newly covered enrollee who had the option to continue with his or her previous health plan or contracting provider and instead voluntarily chose to change health plans or providers

- Completion of covered services by a provider whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity will not be facilitated.

Policy Number:	CA Care Management 04
Policy Title:	Continuity of Care, Transition of Care

Continuity of Care – When it is Applicable

- A hospital, PMG/IPA or PPO provider terminates its contract with Anthem Blue Cross or is terminated by Anthem Blue Cross.
- A newly covered enrollee whose prior coverage was terminated when they were involuntarily switched to an Anthem Blue Cross plan by their employer.
- A newly covered enrollee to Anthem Blue Cross whose prior coverage was terminated when their health benefit plan was withdrawn from the market.
- This policy does not apply to any newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans or providers.

  Completion of covered services by the non-participating treating provider may be available for members who were receiving services for one of the following conditions at the time of the contract termination date or the effective date of coverage for a newly covered enrollee:

  - Acute medical or behavioral health condition: Completion of covered services shall be provided for the duration of the acute condition.

  - Serious chronic medical or behavioral health condition: Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultation with the member and the terminated provider or non-participating provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered enrollee.

  - Pregnancy: Completion of covered services shall be provided for the duration of the pregnancy, regardless of trimester, and during the immediate postpartum period.

  - Terminal Illness: Completion of covered services shall be provided for the duration of the terminal illness, which may exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered enrollee.

  - Care of a newborn child between birth and age 36 months: Completion of covered services shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered enrollee.

  - Performance of a surgery or other procedure that is authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

Continuity of Care – When it is Not Applicable:

- Newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans or providers.
- Member voluntarily changed plans or providers and that election is what has caused their treating provider to be non-participating.
- Authorization of ongoing treatment with a provider when the provider's termination is based on reasons relating to medical disciplinary cause or reason, as defined by California Business and Professions Code Section 805(a)(6), or fraud or other criminal activity.
  - In these cases, the member's transition plan is designed to assist the member in the selection of a new provider.
- Treating physician is a participating provider.
- The member withdraws the request.
- Request is for change of Primary Care Physician (PCP) only (refer to Member Services).
- Anthem Blue Cross coverage is not selected.
- Date of service is prior to effective date with Anthem Blue Cross.
- Course of treatment has been completed.
- Services requested are covered under a global fee that has already been paid in full.
- Requested services are not a covered benefit under the member's Anthem Blue Cross plan.
- Newly covered enrollee who will have out-of-network or Point-of-Service (POS) coverage and the provider requested has a PPO contract with Anthem Blue Cross.
- Member's provider will not accept compensation at the rates and methods of payment similar to those used by Anthem Blue Cross for currently contracting, non-capitated providers providing similar services and who are practicing in the same or similar geographic area as the terminated provider.
- Member is receiving care through an Employee Assistance Program (EAP).
  Note: Any transition issues relating to an EAP will be handled by EAP Operations.
- Members who do not have fully insured plans may be subject to variations in COC/TOC eligibility based on self-funded client's provisions.

Policy Number:	CA Care Management 04
Policy Title:	Continuity of Care, Transition of Care

Definitions:

Acute condition - a medical or behavioral health condition that involves a sudden onset of symptoms due to an illness, injury, or other medical or behavioral health problem that requires prompt medical attention and that has a limited duration.

Continuity of Care (COC) – a process of authorizing an in-network rate for a member to continue medical/behavioral health care services with a terminating provider under specified conditions, to complete a course of treatment and to facilitate a change in providers, when appropriate, at a time when the member can be safely transitioned to a participating provider.

Co-payment - the member's payment responsibility to the provider as defined in their Explanation of Benefits (EOB).

Deductible - the amount of charges some members must pay for any covered expense before selected benefits are available under their plan as described in the member's Evidence of Coverage (EOC).

Employee Assistance Program (EAP) – an employer program to provide support and resources for various stages of life including, but not limited to, professional, confidential counseling and consultation, etc.

Independent Physician Association (IPA) – an incorporated association of physicians that has entered into an arrangement (with Anthem Blue Cross) to furnish medical services to HMO members.

In-network rate – the rate Anthem Blue Cross pays to currently contracted non-capitated providers providing similar services in the same or similar geographic area as the terminating or non-participating provider.

Medical Director – a California licensed physician employed by Anthem Blue Cross who serves as a referral source for other clinical staff.

Medical Management Nurse – licensed nurse employed by Anthem Blue Cross who possesses skills in clinical practice who functions as part of the TA Team in facilitating COC/TOC.

Medical Management system - on-line system used by TA Team to document and track member specific interventions.

Newly covered enrollee – any member new to Anthem Blue Cross. For example, the member may be part of a new employer group or a new enrollee to an existing employer group, or a new enrollee whose prior coverage was terminated when their health benefit plan was withdrawn from the market.

Non-participating provider - a provider that does not have an Anthem Blue Cross plan agreement in effect at the time services are rendered.

Out-of-network benefit level – the difference between the non-participating provider's billed charge and the maximum allowed amount in addition to any coinsurance, co-payments, deductibles, and non-covered charges.

Participating Medical Group (PMG) - a group of physicians who has an agreement with Anthem Blue Cross to furnish medical services to Anthem Blue Cross HMO members.

Participating provider - a provider with an Anthem Blue Cross medical services agreement in effect at the time services are rendered.

Peer Clinical Reviewer (PCR) - a California licensed physician or a California licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider. Only a Peer Clinical Reviewer may deny or modify requests for authorization of health care for a covered person for reasons of medical necessity.

Pregnancy – a pregnancy is the three trimesters of pregnancy and the immediate postpartum period.

Provider - a person who is a licentiate, as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 of Division 2 of the Business and Professions Code.

Serious chronic condition - a medical or behavioral health condition due to a disease, illness, or other medical or behavioral health problem or medical or behavioral health disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration

Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less.

Terminated provider - a provider whose Anthem Blue Cross contract is terminated or not renewed.

Transition Assistance (TA) Team – team of licensed clinical professionals and specially trained non-clinical professionals who are conversant with the COC/TOC policy.

Transition of Care (TOC) - a process of authorizing an in-network rate for a newly covered enrollee to continue medical/behavioral health care services with a non-participating provider under specified conditions, to complete a course of treatment and to facilitate a change in providers, when appropriate, at a time when the member can be safely transitioned to a participating provider.

Policy Number:	CA Care Management 04
Policy Title:	Continuity of Care, Transition of Care

Procedure:

Anthem Blue Cross members are notified of their right to COC/TOC per *Policy H1 Termination of Provider – Enrollee Notification*, during open enrollment, in their Combined Evidence of Coverage and Disclosure Forms, and upon request.

Members may request COC/TOC by calling the Member Services number that is provided to them or is located on the back of their insurance card. Member Services Representatives will complete and forward the request for COC/TOC (See Attachment) on behalf of the member.

Once a request has been received the TA Team is responsible for gathering information from the written request and on-line systems, ensuring eligibility and establishing a case on the Medical Management system for documentation of all information, interventions, and progress.

The TA Team places telephone calls to the requesting member, as well as any providers necessary to assess member needs, gather clinical information, and develop a customized plan of care. Additionally, the TA team will make referrals to any appropriate Anthem Blue Cross resources, including but not limited to, Case Management.

Determination is made in a timely manner appropriate for the member's clinical condition, but no later than two (2) business days after receipt of all necessary information.

Approval or denial for COC/TOC is made on the basis of the member's specific clinical condition, medical needs, and circumstances. Consideration is given to the potential clinical effects on the member's treatment that would be caused by a change in provider. With the exception of maternity, the determination is not based on the member's diagnosis alone**.**

If the TA Team cannot approve the request for clinical reasons or medical necessity, the request is referred to a Peer Clinical Reviewer (PCR) or Medical Director for determination. In addition to clinical denials, cases are referred to a PCR or Medical Director for review and determination when the Medical Management Nurse questions the appropriateness or quality of the provider's treatment plan.

The TA Team notifies the requesting party (member and/or provider) of the determination by telephone. Written confirmation of an approval decision or an adverse determination is provided to the member and the provider.

COC/TOC will be provided in a manner consistent with professionally recognized, evidence-based standards of practice.

If the requested provider has refused the in-network rates, a letter will be sent to the member advising them of the provider's refusal to accept in-network rates. In accordance with the member's plan, if an HMO/EPO plan member continues care with the non-participating provider, there would be no reimbursement from Anthem Blue Cross, and if a PPO/POS plan member continues care with the non-participating provider, it will be reimbursed at the out-of-network benefit level.

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Monitoring Oversight:
Process reviews are conducted to ensure consistency and efficiency of processes and compliance with policies and guidelines. Opportunities for improvement will be addressed through corrective action plans.

Results of process audits and corrective actions are reported to the West Region Medical Management Quality Review Committee (WRMMQRC).

Summary program statistics and trend reports are made at least annually to the WRMMQRC.

Committee of Approval:
West Region Medical Management Quality Review Committee (WRMMQRC).

Attachment:
A. Continuity of Care/Transition of Care Request Form

Reference Sources:
1. The California Health and Safety Codes:
   - 1373.95
   - 1373.96
2. The California Insurance Code
   - 10133.56
3. Department of Managed Health Care Technical Assistance Guide: Continuity of Care

Approval:
Approval Signatures are retained electronically.

Attachment A

Continuity of Care/Transition of Care Request Form (California)

GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

Purpose of Continuity/Transition of Care
The Transition Assistance Program provides a process that allows continued care for members when:

- Their Primary Medical Group (PMG), Independent Physician Association (IPA), Preferred Provider Organization Provider (PPO Provider), Hospital, or other provider is terminated from the Anthem Blue Cross participating provider network.
- They are a newly covered enrollee to Anthem Blue Cross and their treating provider was part of their previous plan's participating provider network but is not part of the Anthem Blue Cross participating provider network.
- Continuity of care is at risk for reasons over which the member has no control.

Please Note: Members who have **elected** to make changes in their coverage which cause their treating provider to be non-participating are not eligible for this program.

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select a participating provider to meet your ongoing health care needs and you do not need to complete this form. If you need assistance selecting a new provider you should contact Anthem Blue Cross Member Services.

Completing the Continuity/Transition of Care Request Form
You may request Continuity/Transition of Care for completion of covered services by the non-participating treating provider for the following conditions:

- **An acute condition.** An acute condition is a medical or behavioral health condition that involves a sudden onset of symptoms due to an illness, injury or other medical or behavioral health problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- **A serious chronic condition.** A serious chronic condition is a medical or behavioral health condition due to a disease, illness, or other medical or behavioral health problem or medical or behavioral health disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultation with the enrollee and the terminated provider or non-participating provider and consistent with good professional practice.
- **A pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
- **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.
- **The care of a newborn child between birth and age 36 months.**
- **Performance of a surgery or other procedure** that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, please:

- Call the Member Services number on the back of your Anthem Blue Cross card or the Member Services number provided to you in open enrollment and they will assist you with completing your request over the phone.
- Or, fax this completed **California** request form to 1-877-214-1781.

To help ensure that your care is not disrupted, please complete the entire form below. *Only complete this form if you are receiving ongoing care or are scheduled for care.* ***For Medical Care****: If you are changing to a PPO or EPO and your current medical provider is in our network, or if you are changing to an HMO or POS and will stay in your current PMG or IPA, you do not need to complete this form****. If you are in an HMO or POS and your provider is leaving the PMG/IPA, you do not need to complete this form, you need to contact your PMG/IPA and they will assist you with your transition to a contracting provider****. For Behavioral Health Care****: If you are changing plans and your provider is not in the Anthem network, please complete this form.*

Attachment A

Continuity of Care/Transition of Care Request Form (California)

Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Subscriber's Name: _____Subscriber's Anthem Blue Cross ID #:_____

Subscriber's Employer: _____ Date Active with Anthem Blue Cross: _____

Patient's Name: _____ Relationship to Subscriber: _____

Date of Birth: _____ Allergies: _____

Preferred Phone #: _____ ☐Home ☐Work ☐Cell Secondary Phone#:_____ ☐Home ☐Work ☐Cell

Name of Terminating Insurance Plan: _____

Type of Terminating Plan: ☐HMO ☐Vivity ☐POS ☐PPO ☐EPO ☐CDHP ☐OTHER ☐

Member ID and/or Medical Record Number of Terminating Insurance Plan: _____

New Anthem Blue Cross Plan: ☐HMO ☐Vivity ☐POS ☐PPO ☐EPO ☐CDHP ☐OTHER

Are You a New Enrollee to Anthem Blue Cross: ☐Yes ☐No

Name of PMG/IPA with Terminating Plan: _____ Name of New Anthem Blue Cross PMG/IPA: _____

For Network Disruption (PMG, IPA, PPO Provider, or Hospital has terminated from the Anthem Blue Cross Participating Provider Network) please provide the name of the terminating Hospital or Provider: _____

Diagnosis (include pertinent history and physical findings): _____

_____

1. Do you have an upcoming appointment to see a specialist? ☐Yes ☐No

If yes, please provide the applicable information below.

Specialist Type	Provider Name (last, first)	Provider Phone Number	Date of Office Visit	Reason
Heart Specialist				
Lung Specialist				
Blood or Cancer Specialist				
Neurologist				
Infectious Disease Specialist				
Kidney Specialist				
Behavioral Health Specialist				
Orthopedic Specialist				
Obstetrician for pregnancy Due Date: Hospital for delivery:				
Other: Please be specific				

Attachment A

Continuity of Care/Transition of Care Request Form (California)

2. Are you currently receiving any of the following services? ☐ Yes ☐ No

If yes, please provide the applicable information below.

Services	Facility or Company, Medical or Behavioral Health Provider
Clinical Laboratory	
Oxygen	
IV Medication/Chemotherapy	
Physical Therapy	
Radiation Therapy	
Home Therapy	
Rehab Treatment	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health condition	
Dialysis	

3. Do you have any hospitalizations, surgeries or procedures scheduled? ☐ Yes ☐ No

Date _____ Type of Surgery/Procedure _____

Name/Phone Number of Physician performing surgery/procedure _____

Hospital/Facility_____

4. Have you been admitted to the hospital or seen in the emergency room in the past 6 months? ☐ Yes ☐ No

Reason _____ Hospital _____

Date(s) of Service _____

5. Other Needs _____

I hereby authorize the above provider to give the Anthem Blue Cross Transition Assistance Department and/or Care Management any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that the Anthem Blue Cross Transition Assistance Department and/or Care Management may share information and discuss my care with my new Primary Care Physician/Medical Group under my Anthem plan. I understand that I am entitled to a copy of this authorization form.

I also authorize Anthem Blue Cross to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:

☐ Home ☐ Cell ☐ Work ☐ Do NOT leave confidential information on my voice mail

Signature of Patient if 18 or over: Date:

Signature of Parent or Guardian if Patient is under 18: Date: