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

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| **Policy Number:** | CA Care Management 04 |
| **Policy Title:** | Continuity of Care, Transition of Care |
| **Policy Approval Date:** | 11/00 |
| **Policy 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 |
| **Products:** | HMO, POS, PPO, EPO, CDHP, MCS, ASO, Fully Insured, Large Group, Small Group, Individual for Network Disruption only |

**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 provider network
- They are a new enrollee in an Anthem Blue Cross plan (except members with an Individual contract or a newly covered member who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans ) and their treating provider is not part of the Anthem Blue Cross provider network
- Continuity of care is at risk for reasons over which the member has no control

**Policy:**

- COC/TOC through the Transition Assistance Department allows eligible members in a course of treatment to continue otherwise covered services with out-of-network providers until the course of treatment is complete or until it is safe to transition the member to an in-network 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 member were seeing an in-network provider.
- 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 members with an Individual contract or a newly covered enrollee who had the option to continue with his or her previous health plan or contracting provider and instead voluntarily chooses 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.

Continuity of Care – When it is Applicable

- Hospital, PMG/IPA or PPO provider terminates its contract with Anthem Blue Cross or is terminated by Anthem Blue Cross; an enrollee who is involuntarily switched to a new Anthem Blue Cross plan by their employer; or any new enrollee to Anthem Blue Cross (with the exception of a new enrollee with an Individual contract or a newly covered member who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans). Completion of covered services may be available for members with the following conditions:
    - 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 may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider in consultation with the member and the provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date or effective date of a new member.
    - 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.
    - Newborn child (Birth - 36 months): Completion of covered services shall not exceed twelve (12) months from the contract termination or effective date of a new member.
    - Surgery or other procedure that is authorized by the Plan or its delegated provider and is scheduled to occur within 180 days of the contract's termination or effective date of a new member.

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Continuity of Care – When it is Not Applicable:

- New enrollee to Anthem Blue Cross with an Individual contract.
- Newly covered member who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans
- 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 contracted provider.
- The member withdraws the request.
- Request is for change of Primary Care Physician (PCP) only (refer to Customer Care).
- 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 with Anthem Blue Cross.
- New 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.
- New enrollee to Anthem Blue Cross with an Individual contract.
- Member voluntarily changed plans or providers and that election is what has caused their provider to be out-of-network.
- 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 were uninsured prior to their effective date with Anthem Blue Cross.
- New enrollee who is not fully insured may be subject to variations in COC/TOC eligibility based on ASO client's provisions.

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**Definitions:**

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

Balance billing - an action by a provider to bill a member for all charges above the amount considered allowable by the insurer (above the total amount reimbursed by the insurer plus any member co-pay and deductible). Prudent Buyer network providers agree not to balance bill and to accept the Anthem Blue Cross negotiated rates of fee schedule amount as payment-in-full.

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 /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 an in-network provider.

Contract rate – maximum amount payable to participating providers less the member's co-payment amount negotiated or determined by Anthem Blue Cross with participating providers for covered services to members.

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 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.

In network benefit level - the member's co-payment amount calculated as if the provider is contracted with Anthem Blue Cross.

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.

Medical Director - licensed physician employed by Anthem Blue Cross who possesses skills in clinical as well as business practices and 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.

New enrollee – any member new to Anthem Blue Cross. The member may be part of a new employer group or a new enrollee to an existing employer group.

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 pocket expense - the amount of charges some members must pay after benefits have been paid under their plan, or the amount of charges for benefits not covered under their plan including member deductibles, co-payment amounts, or other cost-sharing components.

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 physician or other appropriate behavioral health, dental, or chiropractic professional who is qualified, as determined by the Medical Director to render a clinical opinion about the medical condition, procedures, and treatment under review; holds a current and valid license in the same licensure category as the ordering provider who prescribed the health care service being reviewed or as a doctor of medicine or doctor of osteopathic medicine.

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.

Provider Relations Representative - specially trained non-licensed professionals who provide assistance and support to licensed staff.

Serious chronic condition - a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

a) Persists without full cure or worsens over an extended period of time
b) 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 TA policies.

Transition of Care (TOC) - a process of authorizing an in-network rate for a member to continue medical/behavioral health care services with a terminating/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 an in-network provider.

WRMMQRC – West Region Medical Management Quality Review Committee

**Procedure:**

Anthem Blue Cross members are notified of their right to COC/TOC per Policy H1 and during open enrollment.

Members may request COC/TOC by calling the Customer Care number that is provided to them or is located on the back of their insurance card. Customer Care 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.

HMO member: If the requested provider has refused the Prudent Buyer rates (the rate Anthem Blue Cross pays to currently contracting non-capitated providers providing similar services in the same or similar geographic area as the terminating or non-participating provider) and the member continues care with that out-of-network provider, there would be no reimbursement from Anthem Blue Cross. A letter will be sent to the member advising them of the provider's refusal to accept Prudent Buyer Rates. The member has the option of selecting another in-network provider or paying out-of-pocket for services rendered.

PPO member: If the requested provider has refused the Prudent Buyer rates and the member continues to see that out-of-network provider, Anthem Blue Cross will reimburse that provider at the Prudent Buyer rate, as specified in the Prudent Buyer Plan Participating Physician Agreement. A letter will be sent to the member advising them of the provider's refusal to accept Prudent Buyer rates and the risk of being balance-billed.

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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

**Department Linkages:**

Sales/Contracting/Accounts - National and Local
Utilization Management
Case Management/Disease Management
Grievance and Appeals
Claims - General and Account Specific
Customer Service - General and Account Specific
Compliance
Legal

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Behavioral Health
Peer Clinical Reviewers/Medical Directors

**Approval:**

See Policy & Procedure Cover Sheet for Approval Signatures

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# Continuity of Care/Transition of Care Request Form

**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 new enrollee in an Anthem Blue Cross plan (except members with an Individual contract) 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. (Members who have **elected** to make changes in their coverage which cause them to be out-of-network 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 an in-network 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 Customer Care.

**Completing the Continuity/Transition of Care Request Form**
You may request Continuity/Transition of Care:

- If you are in an active course of treatment for an acute medical condition or a serious chronic condition. **An acute medical condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. **A serious chronic condition** is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you are in an active course of treatment for any behavioral health condition;
- If you are pregnant, regardless of trimester;
- If you have a terminal illness;
- If you have a newborn child between the ages of birth and 36 months. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you have 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 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 Customer Care Number on the back of your Anthem Blue Cross card or the Customer Care number provided to you in open enrollment and they will assist you with completing your request over the phone.
- Or, fax this completed 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.*

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# Continuity of Care/Transition of Care Request Form

***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: _____

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

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<br>Due Date:<br>Hospital for delivery: | | | | |
| Other: Please be specific | | | | |

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# Continuity of Care/Transition of Care Request Form

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 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 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

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