Title:	Transition of Care / Continuity of Care				
Department/Line of Business:	HSD / All Lines of Business				
Approver(s):	HSD Director and Vice President				
Location/Region/Division:	SWHP				
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LINE OF BUSINESS

This document applies to the following line(s) of business:
ALL Lines of Business

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the BSWH P&P Definitions document.

Ancillary Health Care Professional - a health care professional or facility of auxiliary or supplemental services used to support diagnosis and treatment of a condition. These health care professionals include but are not limited to:

- Durable medical equipment ("DME")
- Home health services
- Imaging services
- Infusion centers
- Laboratory services
- Genetic Testing
- Orthotics and prosthetics
- Outpatient cardiac rehabilitation
- Outpatient rehabilitative services (e.g. physical therapy, occupational therapy, cognitive therapy, speech therapy)
- Outpatient surgery centers
- Pharmacy services
- Sleep disorder studies

Member - an individual covered participant or covered dependent.

New Enrollee - a new SWHP/ICSW member or an existing SWHP/ICSW member enrolled into a new medical product (i.e. change in benefit plan network).

Special Circumstances – a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a physical or mental disability, acute condition, life-threatening illness, or who is past the 24th week of pregnancy.

POLICY

Transition of Care ("TOC") refers to the process of transitioning medical care for new enrollees from non-participating health care professionals to participating health care professionals. The TOC process evaluates requests for authorization and reimbursement of a non-participating health care professional at the in-network level of benefits for services that would be considered covered benefits when provided by a participating health care professional. In so doing, the TOC process evaluates clinical contraindications for the immediate transfer of a member from a non-participating health care professional to a participating health care professional including conditions where the transfer of care is not permitted per accreditation standards, regulatory or state requirements, could cause worsening of the condition, reoccurrence, or interfere with anticipated outcomes.

A Transition of Care Request Form is required to evaluate services for TOC coverage and should be submitted no later than thirty (30) calendar days following the effective date of enrollment. However, a thirty (30) day grace period allows requests received sixty (60) days following the customer's new enrollment date.

Services eligible for TOC are subject to benefit plan limitations and end when the one of the following occurs:
- Care for the acute and/or chronic condition is completed;
- Care is successfully transitioned to a participating health care professional;
- Benefit limitations are exceeded;
- Time period approved for TOC coverage is exceeded

Transition of Care Request Form may be received from a member and/or their current physician or healthcare professional. The Health Services Division ("HSD"), Utilization Management Department, manages the TOC requests.

Time period requirements are evaluated by HSD to determine coverage.

Approvals and adverse determinations are provided in writing to the requester/designee. With adverse determinations, customers are advised of their right to appeal and the process for initiating an appeal.

Transition of Care does not apply to Individual Plans.

Continuity of Care ("COC") refers to the continuation of medical care for customers/established enrollees when a participating health care professional (e.g. physician, ancillary and/or facility) leaves the network and ongoing medical care/services are requested as outlined in this policy below.

State/Federal Compliance:
This list is not all-inclusive; please refer to entire listing of state specific requirements
- For HMO/Commercial POS/PPO, the timeline for completion of TOC requests is two (2) business days from receipt of all required information to customer/health care professional notification.
- For Self-funded ASO, the timeline for completion of TOC request is three (3) business days for Urgent and fifteen (15) days for Routine from receipt of all requested information to customer/health care professional notification.

PROCEDURE

Related Documents Requests for TOC for new enrollees should be submitted to Scott and White Health Plan/Insurance Company of Scott and White no later than thirty (30) calendar days following effective date of enrollment.

Timeline for completion of TOC Requests

- For HMO/Commercial POS/PPO, the timeline for completion of TOC requests is two (2) business days from receipt of all required information to customer/health care professional notification.
- For Self-funded ASO, the timeline for completion of TOC request is three (3) business days for Urgent and fifteen (15) days for Routine from receipt of all requested information to customer/health care professional notification.

The member's condition is evaluated by a medical professional to determine medical necessity coverage. The medical professional will request a brief history, treatment plan and/or current evaluation if needed to determine TOC coverage.

Unless otherwise addressed, acute and/or chronic conditions in active treatment may be approved for TOC which are defined as any of the following:

- physician visit or hospitalization;
- documented changes in a therapeutic regimen within twenty-one (21) days prior to the effective date of enrollment;
- conditions where discontinuity could cause worsening of the condition, reoccurrence and/or interference with anticipated outcomes (see "special circumstances")

Note: Elective surgeries scheduled more than twenty-one (21) days preceding eligibility AND within two (2) weeks of the plan effective date will be reviewed on a case-by-case basis by the Medical Director to ensure continuation in quality of care.

Approved requests to cover services provided by a non-participating health care professional at the in-network benefit level will include the following:

- List of the specific services approved
- Specified time period services are approved *(not to exceed 90 calendar days with the exception of pregnancy or approval by Medical Director)*

Requests which cannot be approved by the clinician are referred to the Medical Director for determination.

The Medical Director will review the treating health care professional's treatment plan to assess the individual health care needs of the member and ensure a reasonable transition period to continue his/her course of treatment.

Note: Exceptions may be made on a case-by-case basis to authorize periods longer than the standard ninety (90) calendar days to preserve continuity of care for a defined and limited treatment interval (e.g., a chemotherapy treatment plan that is expected to be completed within one hundred-twenty (120) days).

The Medical Director will complete the required documentation and will forward to the appropriate clinician for recording in care management system and member and/or health care professional notification.

Coverage determination letter will be completed and sent to the member and/or requesting health care professional. All adverse determination letters will include the rationale for the decision and guidance on obtaining information on participating health care professionals are forms, other policies or procedure, or other types of internal documents.

ATTACHMENTS

None.

RELATED DOCUMENTS

Continuity of Care/Transition of Care Request Form (HSD.F001.V02 11)

REFERENCES

TIC Ch. 1419 §843.309
TAC Title 28 Part 1 Chapter 11 Subchapter J RULE §11.901