# Cigna

| Policy Name<br>Transition of Care Service Requests For New Customers | | Policy Number<br>UM-35 |
|---|---|---|
| Business Segment<br>Healthcare | | |
| Initial Effective Date:<br>09/01/00 | Policy Committee Approval Date(s):<br>04/10/12; 02/26/13; 11/26/13; 08/26/14; 10/14/14; 10/28/14; 12/09/14 | |
| Replaces Policies:<br>CGMM-III-10 Transition of Care Services for New Customers<br>UM-US-052 Transition of Care | | |

## Purpose:

The purpose of this policy is to establish a consistent process for evaluating and responding to Transition of Care requests for new enrollees.

## Policy Statement:

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 customer 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 new enrollee is defined as a new Cigna Healthcare customer or an existing Cigna Healthcare customer enrolled into a new medical product (i.e. change in benefit plan).

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



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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.

Review for medical necessity will not be performed for Ancillary Services Transition of Care requests except in specific states as noted in the State Compliance section and/or services provided by a licensed practitioner. An administrative denial letter is sent to the customer and/or requesting health care professional.

For purposes of this policy, the definition of an ancillary health care professional is 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)
- Health education services
- Hearing aids
- Home health services
- Imaging services
- Infusion centers
- Laboratory services
- Licensed Midwife working independently and not billing under an OB/GYN (unless otherwise specified by state mandates)
- Nurse Surgical Assistant
- Orthotics and prosthetics
- Outpatient cardiac rehabilitation
- Outpatient rehabilitative services (e.g. physical therapy, occupational therapy, cognitive therapy, speech therapy)
- Outpatient surgery centers
- Pharmacy services
- Physician extenders including physician assistants, nurse practitioners, clinical nurse specialists
- Sleep disorder studies

<u>Transition of Care does not apply to Individual Family Plans (IFPs) unless there are state requirements</u>

Definitions:

For purposes of this policy “customer” means an individual participant or member.



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COC: Continuity of Care (COC) refers to the continuation of medical care for customers when a participating health care professional (may be physician, ancillary and/or facility) leaves the network and ongoing medical care/services are requested as outlined in policy UM-41.

State/Federal Compliance:
This list is not all inclusive; please refer to iComply for entire listing of state specific requirements

- For California HMO, the timeline for completion of TOC requests is 5 business days from receipt of all required information to customer/health care professional notification.
- Medical Necessity reviews for ancillary services/health care professionals for Transition of Care will be performed by a physician reviewer in the following states: California, Colorado, District of Columbia, Illinois, Indiana, Iowa, Louisiana, Maine, Missouri, Nebraska, New Jersey, New Mexico, North Carolina, New York, Oregon, South Dakota, Texas and Virginia.
- Mandated benefits may apply for several states
- Mandated turnaround times requirements may apply for several states
- Reviewer qualifications for peer review and licensing may apply for several states

NOTE: State mandates supercede Cigna Healthcare standard time periods and conditions

Procedure(s):

A. Transition of Care Request Form may be received from a customer and/or their current physician or healthcare health care professional. These requests are managed nationally by the Utilization Management area with the exception of the following:

   - Requests for transition of behavioral health services are referred to the customer's behavioral health care professional
   - Requests for services related to transplant and/or customers actively enrolled in Transplant Case Management are referred to the Transplant Case Manager for review

B. Time period requirements are evaluated to determine coverage.

   - Requests for TOC should be submitted no later than 30 calendar days following effective date of enrollment.
   - Timeline for completion of TOC requests is 8 business days, unless a stricter timeframe is required by state law, from receipt of all required information to customer/health care professional notification.



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C. The customer's condition is evaluated by a nurse to determine coverage. The nurse will request a brief history, treatment plan and/or current evaluation if needed to determine TOC coverage.

D. Unless otherwise addressed by a state mandate, acute and/or chronic conditions in active treatment which may be approved as TOC are defined as any of the following:

- physician visit or hospitalization;
- documented changes in a therapeutic regimen within 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

E. Unless otherwise addressed by a state mandate, the below TOC requests may be approved for reimbursement of a non-participating health care professional at an in-network benefit level for up to 90 calendar days.

- Terminal conditions
- Acute and/or chronic conditions in active treatment
- 2nd and 3rd trimester of pregnancy including post-partum care
- Hospital confinement on the plan effective date for plans which do not have extension of benefit provisions

NOTE: Elective surgeries scheduled more than 21 days preceding eligibility AND within 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.

F. Non-participating facility services associated with a TOC request may be approved for in-network reimbursement for a service that qualifies for coverage under TOC when the physician does not have privileges at a participating facility offering those services.

G. 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)*

H. Requests which cannot be approved by the nurse are referred to the Medical Director for determination. The Medical Director reviews the treating health care professional's treatment plan to assess the individual health care needs of the customer and ensure a reasonable transition period to continue his/her course of treatment. Exceptions may be made on a case-by-case basis to authorize periods longer than the standard 90 calendar



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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 120 days).

I. The Medical Director will complete the required documentation and will forward to the appropriate staff customer for recording in UM system and customer and/or health care professional notification.

J. Coverage determination letter is sent to the customer and/or requesting health care professional. An adverse determination will include the rationale for the decision and guidance on obtaining information on participating health care professionals

HIPAA Applicable Policies & Procedures:
Minimum Necessary Use, Disclosure and Request of Protected Health Information
Privacy and Confidentiality of Individually Identifiable Protected Health Information
Confidential Communications
Physical, Technical and Administrative Safeguards
Restrictions on the Use and Disclosure of Protected Health Information
Privacy Complaints
Amendment of Designated Record Set, Statement of Disagreement and Revocation Policy
Authorization
Verification and Disclosure

Related Policies and Procedures:
Adverse Determination Notification Elements Policy
Timeliness of Health Services Decisions Policy
Interact and Medical Director Case Review Policy
Network Adequacy Provision (NAP) Policy
Pre-Certification of Inpatient, Outpatient and Ambulatory Services Policy

Links/PDFs:
Attachment 1: States with Transition of Care Laws that Deviate From Cigna Standard Process
Attachment 2: States with Transition of Care Laws that Do Not Deviate from Cigna Standard Process



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## STATES WITH TRANSITION OF CARE LAWS THAT DEVIATE FROM (ARE RICHER THAN) Cigna STANDARD PROCESS

ATTACHMENT 1: Last reviewed November 2013

| State | Timeframe and Conditions Eligible for Transition of Care (TOC) | Deviation from Cigna Standard Process |
|---|---|---|
| Cigna Standard | TOC period = 90 days from effective date<br><br>Customer/health care professional must submit request within 60 days from effective date.<br><br>• Terminal conditions<br>• Acute conditions in active treatment<br>• 2nd or 3rd trimesters of pregnancy and postpartum care<br>• Facility services for inpatient care, maternity and hospice when non-par health care professional services are approved and the health care professional does not have privileges at par facility. | |



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STATES WITH TRANSITION OF CARE LAWS THAT DEVIATE FROM
(ARE RICHER THAN) Cigna STANDARD PROCESS

ATTACHMENT 1: Last reviewed November 2013

| State | Timeframe and Conditions Eligible for Transition of Care (TOC) | Deviation from Cigna Standard Process |
|---|---|---|
| California<br><br>TOC mandate s apply to:<br><br>HMO/Network (CA residents) EPO/OAPINN<br><br>A new enrollee is defined as a new Cigna Healthcare customer or an existing Cigna Healthcare customer enrolled into a new medical product (i.e. change in benefit plan) or network. | • An acute condition, for the duration of the acute condition. An "acute 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.<br>• A serious chronic condition, for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another health care professional, as determined by the Cigna Medical Director (or designee) in consultation with the enrollee and treating health care professional, consistent with good professional practice. This period shall not exceed 12 months from the health care professional's termination date or the effective date of coverage for the newly covered enrollee. A "serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical 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.<br>• A pregnancy, for the duration of the pregnancy (three trimesters) and the immediate postpartum period.<br>• A terminal illness, for the duration of the terminal illness. A "terminal illness" is an incurable or irreversible condition that has a high probability of causing death within one year or less.<br>• Care of a newborn child whose age is between birth and age 36 months, regardless of whether the child is undergoing an active course of treatment, for a period not to exceed 12 months.<br>• Performance of surgery or other procedure that has been authorized by the plan, as part of a documented course of treatment that is to occur within 180 days of the health care professional's termination date or the effective date of coverage for a newly covered employee.<br>NOTE: In relation to groups delegated for Utilization management, review for TOC is NOT delegated and remains the responsibility of Cigna. Cigna will coordinate the outcome of the review with the applicable health care professional group. | • Must provide TOC for acute condition for duration of condition (may exceed 90 days)<br>• Must provide TOC for serious chronic conditions up to 12 months<br>• TOC for pregnancy may begin during 1st trimester<br>• TOC for newborns age birth – 36 months, up to 12 months of TOC coverage<br>• Possible TOC for pre-approved surgery/procedure |



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## STATES WITH TRANSITION OF CARE LAWS THAT DEVIATE FROM (ARE RICHER THAN) Cigna STANDARD PROCESS

ATTACHMENT 1: Last reviewed November 2013

| State | Timeframe and Conditions Eligible for Transition of Care (TOC) | Deviation from Cigna Standard Process |
|---|---|---|
| Connecticut | • Where Cigna plan replaces other coverage and covers services related to hospital confinement and/or total disability, period of transitional care must be "clinically appropriate" for the customer's medical condition. | • No specific time limit on transition of care when the customer is hospital confined or is totally disabled.<br>• Transition period must be "clinically appropriate" for customer's condition. |
| Maine | • At least 60 days of TOC<br>• Pregnancy through postpartum care | • Must provide TOC coverage for *at least* 60 days |
| Massachusetts | • At least 30 days of TOC<br>• Pregnancy including first postpartum visit<br>• Until participant's death if terminally ill | • Must provide TOC coverage for terminal illness until participant's death – no time limit<br>• Must provide TOC coverage for *at least* 30 days |



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| State | Timeframe and Conditions Eligible for Transition of Care (TOC) | Deviation from Cigna Standard Process |
|---|---|---|
| Minnesota | • Up to 120 days TOC for acute conditions and pregnancy beyond 1st trimester<br>• For rest of participant's life if life expectancy is 180 days or less (or, up to 180 days max TOC)<br>• Allows same TOC for customers receiving culturally appropriate services or who do not speak English and there is no new health care professional in the network that can provide these services | • Must allow 120 days of TOC<br>• Must provide TOC for terminal illness for up to 180 days (if life expectancy is 180 days or less)<br>• Must allow TOC from 1st trimester of pregnancy<br>• Must allow TOC for customers receiving culturally appropriate services or who do not speak English (provided there is no comparable health care professional in-network) |
| New Jersey | • For new enrollees, Cigna must accept prior carrier's authorization for care from Cigna non-participating health care professionals. Coverage may be subject to the customer's new Cigna plan, including benefit plan limits, health care professional network access (e.g. if lock in product, must see par health care professional), cost sharing INN vs. OON if customer is seeing a non-par health care professional, must pay OON, etc. | • Must accept prior carrier's authorization for care from Cigna non-participating health care professionals subject the Cigna plan's coverage provisions. |
| New Mexico | • Not less than 30 days TOC<br>• Pregnancy through postpartum care | • Must provide TOC coverage for *at least* 30 days |



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## STATES WITH TRANSITION OF CARE LAWS THAT DEVIATE FROM (ARE RICHER THAN) Cigna STANDARD PROCESS

ATTACHMENT 1: Last reviewed November 2013

| State | Timeframe and Conditions Eligible for Transition of Care (TOC) | Deviation from Cigna Standard Process |
|---|---|---|
| New York | • Up to 60 days TOC<br>• Pregnancy through postpartum care | • Standard meets state requirements, except that appeals must be handled under the terms of the NY Administrative Appeal P&P for fully insured customers<br>NOTE: NY has laws which govern referral/auth of care for customers with life-threatening or degenerative or disabling conditions, to avoid improper denials of non-par care. See CI titled, "Health care professional Referrals: Referrals" for details. |
| North Carolina | • Up to 90 days TOC (including pregnancy from 2nd trimester)<br>• Until customer's death if terminally ill | • Must provide TOC for terminal illness until participant's death – no time limit |
| Texas | • No law | • Appeals must be handled under the terms of the TX Administrative Complaint & Appeals P&P for fully insured customers |



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## STATES WITH TRANSITION OF CARE LAWS THAT DEVIATE FROM (ARE RICHER THAN) Cigna STANDARD PROCESS

ATTACHMENT 1: Last reviewed November 2013

| State | Timeframe and Conditions Eligible for Transition of Care (TOC) | Deviation from Cigna Standard Process |
|---|---|---|
| Washington | • For PCPs, at least 60 days or for plans with open enrollment periods, until the end of the next open enrollment period | • For PCPs, at least 60 days or for plans with open enrollment periods for selection of new PCPs, until the end of the next open enrollment period<br>• For all other health care professionals, follow Cigna standard. |



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STATES WITH TRANSITION OF CARE LAWS THAT DO NOT DEVIATE FROM
Cigna STANDARD PROCESS

ATTACHMENT 2: Last reviewed November 2013

| STATE | TRANSITION OF CARE (TOC) REQUIREMENTS |
|---|---|
| Cigna Standard | TOC period = 90 days from effective date<br><br>Customer/health care professional must submit request within 45 days from effective date.<br><br>• Terminal conditions<br>• Acute conditions in active treatment<br>• 2nd or 3rd trimesters of pregnancy and postpartum care<br>• Active engagement in acute inpatient rehab program for a condition with a new onset within the 21 days preceding eligibility. Coverage is subject to therapy limitations under benefit plan.<br>• Facility services for inpatient care, maternity and hospice when non-par health care professional services are approved and the health care professional does not have privileges at par facility. |
| Arizona | • 30 days TOC for life threatening condition<br>• Up to 6 weeks after delivery |
| Arkansas | • Until treatment ends<br>• Up to 90 days TOC |
| | |



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## STATES WITH TRANSITION OF CARE LAWS THAT DO NOT DEVIATE FROM Cigna STANDARD PROCESS

ATTACHMENT 2: Last reviewed November 2013

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|---|---|
| Florida | • Law requires insurance carriers to extend maternity benefits for customers insured under a non ASO, non HMO plan for the entire pregnancy through postpartum care. TOC requests related to maternity care are denied for these customers.<br>• Law requires coverage of a mid-wife for home birth settings for customers insured under a non ASO, HMO plan. Refer to NAP policy. |
| Illinois | • Up to 90 days TOC<br>• Pregnancy including postpartum care |
| Iowa | • Up to 90 days<br>• Pregnancy through postpartum care |
| Missouri<br>*(law is HMO only)* | • Up to 90 days TOC |
| Pennsylvania | • Up to 60 days TOC<br>• Pregnancy through postpartum care |
| Vermont | • Up to 60 days TOC (or until TOC to new health care professional)<br>• Pregnancy through postpartum care |



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States without TOC laws:
Alabama, Alaska, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virgin Islands, Virginia, West Virginia, Wisconsin, and Wyoming



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