I. Description:

To establish a standardized and appropriate process for prior authorization requests related to the continuity of care for members who have recently changed health insurance carriers and/or who wish to maintain an existing relationship with an out-of-network provider.

II. Policy/Criteria:

Continuity of care is an important consideration when a request for prior authorization is received for services to be performed at a non-preferred/out-of-network facility and/or when a member transitions from one health plan to another. eviCore is not delegated the decision regarding the availability for continuity of care opportunities. However, eviCore will have a process in place to communicate with contracted health plans or process requests, based on health plan requirements and/or state regulatory guidelines, regarding a request for the continuation of medically necessary services, where applicable, for Commercial, Medicare, and Medicaid members that are transitioning from one plan to another. This process of communication and facilitation of member care is agreed upon in concert with the applicable health plan and will vary given eviCore's relationship and contractual obligations with multiple clients and/or state regulatory guidelines.

III. Responsibility:

Medical Management Department, Operations Department, Contact Center (Intake and Customer Service)

IV. Process:

1. When a request for continuity of care for a member that has transitioned from one plan to another is received by eviCore and may or may not have an authorized service(s) in effect, the Contact Center agent will identify the member's health plan and refer to the agreed upon workflow to support the member's plan of care, maximize member outcomes, and assure care is provided uninterrupted.
2. When a request for out-of-network services for a member reported to be eligible for continuity or transition of care opportunities is received by eviCore, the Contact Center agent will identify the member's health plan.
3. Contact Center agents may select a requested non-participating or out-of-network facility, dependent on documented health plan requirements, when the member history, as reported by requesting practitioner, indicates previously approved requests (within the last 12 months) for identical Current Procedural Terminology (CPT) and International Statistical Classification of Diseases and Related Health Problems (ICD) codes.
4. Clinical staff may approve an out-of-network request and/or continuity of care for a member that has changed plans for continuity of care reasons, based on the following examples of

continuity of care reasons, as directed by contracted health plans, or under guidance by state regulatory guidelines.

5. Examples of continuity of care reasons:
   a) Member transitions from one health plan to another during an open enrollment period
   b) Member has enrolled in a new Medicare Advantage plan after starting an active course of treatment under their previous plan
   c) Ongoing evaluation of oncologic disease
   d) If the current out-of-network request is part of an ongoing diagnostic evaluation of a known cancer diagnosis.
   e) If there has been a period of time greater than twelve (12) months since the last test of the same type being requested now, and the requesting practitioner determines that continuity of care is dependent on the requested test being performed at the initial performing facility.
   f) Continuity of care related to recent hospitalization (within past 12 weeks): If the current test requested is part of the ongoing diagnostic evaluation of the clinical condition for which the member was hospitalized and comparison or follow-up testing is required and the requested test is to be performed at the same hospital, as reported by requesting practitioner. If more than twelve (12) weeks, the reviewing Medical Director must determine if the continuity of care request is appropriate.
   g) Continuity of care related to previous studies evaluating the same clinical condition (such as Computed Tomography [CT] Chest to follow solitary pulmonary nodules, CT Abdomen to follow liver disease, or CT Abdomen to follow kidney lesions) will be reviewed and a determination made by the reviewing Medical Director.
   h) Continuity of care related to pending surgical interventions (such as CT Abdomen at hospital where colon resection will be performed or Magnetic Resonance Imaging [MR] Brain for Tumor mapping). Note: Some health plans include pre-surgical testing in the inpatient rates- please check the business rules for the health plan regarding these studies and process the request as a denial (non-covered benefit).
6. Under the following scenario, Medical Directors must evaluate the presented clinical information prior to approving a request for continuity of care:
   a. Continuity of care related to hospitalization (greater than 12 weeks): If the current testing is part of the ongoing diagnostic evaluation of the clinical condition for which the member was hospitalized and comparison or follow-up testing is required and the required test is to be performed at the same hospital, as reported by requesting practitioner.
7. Out-of-network requests for continuity of care reasons should <u>not</u> be approved under the following scenarios:
   a. The member had previous, unrelated testing at the requested facility and desires to continue receiving care at the facility.
   b. The member had previous low-tech imaging studies (such as plain films or ultrasound) and desires to return for high-tech imaging studies. The member should be instructed to obtain films from the first facility and bring them to the approved facility at the time of the study.
   c. Scheduling convenience.
8. Clinical Reviewer Supervisor or Nurse Subject Matter Expert should evaluate clinical information before out-of-network requests for continuity of care are selected for override reasons.

Centers for Medicare and Medicaid Services (CMS):

Regulation	Requirement
42 CFR 422.112	**42 CFR 422.112 (b) (8):** (i) With respect to basic benefits, policies for using prior authorization that at a minimum include that for enrollees undergoing an active course of treatment— (A) Approval of a prior authorization request for a course of treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history, and the treating provider's recommendation; and (B) A minimum 90-day transition period for any active course(s) of treatment when an enrollee has enrolled in an MA plan after starting a course of treatment, even if the service is furnished by an out-of-network provider. This includes enrollees new to a plan and enrollees new to Medicare. The MA organization must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days. (ii) For purposes of this paragraph (b)(8), the following definitions apply: (A) *Course of treatment* means as a prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan. (B) *Active course of treatment* means a course of treatment in which a patient is actively seeing the provider and following the course of treatment.

State Specific Requirements:

State	Requirement
Florida	**42 CFR 438.208(b)** and the **Florida Medicaid Health Plan Model Contract** allows Medicaid enrollees to continue care with a terminated treating provider, during a transitional period when such care is medically necessary and there is written documentation of prior authorization of ongoing covered services. Services will be allowed for thirty (30) days after the effective date of the enrollment, or until the enrollees Primary Care Physician reviews the enrollee's treatment plan whichever comes first.
Georgia	**The Rules and Regulations Secretary of State of Georgia, Chapter 290-5-37.03(d)** and the **Georgia Department of Community Health Medicaid Contract** allows enrollees to receive services without a referral or prior authorization from the current provider for procedures or services that are scheduled to occur after effective date of the new plan or that have been prior authorized by DCH or the previous plan, or in ongoing treatment for a period of thirty (30) days.
Illinois	**215 ILCS 134/40: Managed Care Reform and Patient Rights Act and the Contract for Furnishing Health Services Section 4.6** Provide for transition of care for a period of ninety (90) days from the effective date of the enrollment for: a. members in an ongoing course of treatment, or b. members that have entered the third trimester of pregnancy at the effective date of the enrollment
Kentucky	**42 CFR 438.208(b)**, **Kentucky revised Statutes 304.17A-643**, provide for medically necessary covered services with a provider outside of the network for a transition period of ninety (90) days.

Minnesota	**62M.17 CONTINUITY OF CARE; PRIOR AUTHORIZATIONS** **Subdivision 1.Compliance with prior authorization approved by previous utilization review organization; change in health plan company** If an enrollee obtains coverage from a new health plan company and the health plan company for the enrollee's new health benefit plan uses a different utilization review organization from the enrollee's previous health benefit plan to conduct utilization review, the health plan company for the enrollee's new health benefit plan shall comply with a prior authorization for health care services approved by the utilization review organization used by the enrollee's previous health benefit plan for at least the first 60 days that the enrollee is covered under the new health benefit plan. In order to obtain coverage for this 60-day time period, the enrollee or the enrollee's attending health care professional must submit documentation of the previous prior authorization to the enrollee's new health plan company according to procedures in the enrollee's new health benefit plan. During this 60-day time period, the utilization review organization used by the enrollee's new health plan company may conduct its own utilization review of these health care services.
Missouri	**The State of Missouri RFP B3Z09135 Medicaid Managed Care Section 2.5.8** provides for members transitioning to a new health plan as follows: a. non-pregnant member receiving a physician authorized course of treatment outside of the network may continue to receive such treatment for a period of sixty (60) days or until the member has seen the assigned Primary Care Physician; b. members in their third trimester of pregnancy may continue to receive services from their prenatal care provider through the postpartum period (defined as sixty (60) days from the date of birth).
New York	**New York State Public Health Law Section 4403.6F** provides for service continuation for new enrollees during a transitional period for up to sixty (60) days from the date of enrollment when: a. the enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition, or b. the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery
Ohio	**The Ohio Medical Assistance Provider Agreement for Managed Care Plans Appendix C. 29(i) 42 CFR 438.206 (3)** and **OAC rules 5101:3-26-03.1, 5101:3-2-07.1 and 5101:3-26-02.1 F. 1-5** provide for a member when transitioning from another Medicaid plan to continue an ongoing course of treatment with the current physician outside of the network during a transitional period of sixty (60) days.

Revision Dates

08/31/2023-2024 CMS Final Rule update
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11/20/2020
01/07/2019

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Approved by: _____ **Date:** **08/31/2023**
eviCore Compliance Officer