Keywords: continuity, Non Network, Out of Network, termination

II. POLICY DISCLAIMER

Johns Hopkins HealthCare LLC (JHHC) provides a full spectrum of health care products and services for Employer Health Programs, Priority Partners, Advantage MD and US Family Health Plan. Each line of business possesses its own unique contract and guidelines which, for benefit and payment purposes, should be consulted to know what benefits are available for reimbursement.

Specific contract benefits, guidelines or policies supersede the information outlined in this policy.

III. POLICY

This policy addresses continuity of care for newly enrolled members and current members impacted by network provider termination. Requests for access to non-participating providers in the absence of continuity of care cases is also addressed. For benefit guidelines, refer to the Plan Member Handbooks and Provider Manuals in addition to the below resources.

For Priority Partners (PPMCO): refer to:
IV. POLICY CRITERIA

A. Access to Non-Participating Providers for Continuity of Care: Requests to access non-participating providers for continuity of care will be reviewed by a JHHC Medical Director. Access to non-participating providers for continuity of care is subject to the contractual limitations and exclusions or exceptions as set forth in Plan Benefit Guidelines. Plan Benefit Guidelines should be consulted and supersede the criteria below.

To promote reasonable continuity of care and care transitions the following guidelines have been established.

Note: A history of a prior visit, course of treatment, or surgery with a non-participating provider does not always constitute a continuity of care case. The member must be in an active course of treatment at the time of change in health plan or provider termination from the Plan network to meet eligibility requirements for access to non-network providers under the continuity of care provision.

1. Newly Enrolled Members: *(This section is applicable to Advantage MD, EHP, & PPMCO)*
   a. Newly enrolled members, who have been receiving covered services from a non-participating provider at the time of the change in health plans on the effective date of contract termination, may be permitted to receive services from the non-participating provider for a limited time.
   b. The duration of time for the care transition to a network provider, except for pregnancy as noted below, is limited to 90 days or until the active course of treatment is completed, whichever is sooner.
   c. Newly enrolled members must have been receiving treatment for one of the following conditions at the time of the change in health plans on the effective date of contract termination:(Refer to Definitions section)

   i. **Acute Condition:** Examples of qualifying acute conditions include:
      • bone fractures
      • myocardial infarction
      • other acute trauma or surgery
      • acute exacerbation of a chronic condition (i.e. asthma, CHF, COPD)
   ii. **Serious Chronic Condition:** Examples of qualifying chronic conditions include:
      • Current cancer treatments (i.e. radiation, chemotherapy, surgery)
      • Staged surgery in process (i.e. cleft palate repair, breast reconstruction after mastectomy)
      • HIV/AIDS
      • Organ transplants
iii. **Pregnancy**: Diagnosed and documented by the non-participating provider prior to the newly enrolled member’s effective date of coverage. Coverage for the non-participating provider will be for the duration of the pregnancy and the initial postpartum visit.

iv. **Other Condition on Which the Plan and Non-participating Provider Agree**

v. **Limited Use of Prior Plan Authorization**: *(v. is applicable to PPMCO)*

Prior authorization from former health plan for health care services that are covered benefits under PPMCO may qualify for access to a non-participating provider. Documentation of prior authorization and notification to the Plan is required. Refer to the Maryland Insurance Bulletin 14-22 in Policy section above.

2. **Current Members Affected by a Provider Termination from Plan Network**: *(This section is applicable to Advantage MD, EHP, PPMCO, & USFHP)*

   a. Members who are affected by the termination of a primary care practitioner or practice group or a specialist may be allowed continued access to the non-participating practitioner to complete an active course of treatment.

   b. The practitioner’s contract must be discontinued for reasons other than due to professional review actions, as defined in the Health Care Quality Improvement Act of 1986.

   c. JHHC will allow affected members continued access to the terminated practitioner for a temporary period of time as described below:

      i. **Chronic or Acute Condition**: Continuation of treatment through the current period of active treatment, or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition, OR;

      ii. **Pregnancy**: Continuation of care through the postpartum period for members in their second or third trimester of pregnancy, diagnosed and documented by the non-participating provider.

3. **Continuity of Care Termination**: *(This section is applicable to Advantage MD, EHP, PPMCO, & USFHP)*

   In ALL instances, covered services for the continuity of care condition under treatment by the non-participating or terminated provider will be considered complete when BOTH of the following have been met:

   a. The member’s continuity of care condition under treatment is medically stable, AND;

   b. There are no clinical contraindications that would prevent a medically safe transfer to a participating provider as determined by a JHHC medical director in consultation as needed with the member, the treating non-participating or terminated provider, and the member’s assigned participating provider.

4. **Exclusions**: *(This section is applicable to Advantage MD, EHP, PPMCO, & USFHP)*

Access to non-participating providers under the continuity of care provision excludes the following; this list is not all-inclusive.

   a. Member preference in the absence of one of the above conditions listed 1 and 2 above.

   b. Past healthcare history with a non-participating provider, unless criteria in 1 or 2 above are met.

B. **Other Access to Non-Participating Providers**: *(This section is applicable to Advantage MD, EHP, PPMCO, & USFHP)*

Access to non-participating providers in the absence of a confirmed continuity of care case (as noted in A above) will be reviewed by a JHHC medical director and are subject to the contractual limitations and exclusions or exceptions as set forth in Plan Benefit Guidelines. Plan Benefit Guidelines should be consulted and supersede the criteria below.
1. When benefits are provided under the member's Plan contract, access to non-participating providers may be approved for the following indications:
   a. Covered medically necessary care cannot be provided within the participating network according to the Plan's travel access standard and/or wait time standard.
   b. Member requires inpatient discharge and medical condition or body habitus precludes transfer to a participating facility. Documentation of attempted placement at participating facilities is required.
   c. Member requires a very specialized covered service that is not available within the Plan network, or not available timely based on medical necessity.
   d. Covered service/supply determined to be medically necessary can only be provided from a non-participating provider (i.e. sole source provider of a service).
   e. When benefits allow on a case-by-case basis to provide a temporary bridge in care if member is out of the Plan's geographic area and medical condition prohibits access to care from a participating provider.

2. When a covered medically necessary service cannot be provided by a participating provider in the Plan as noted in a-e above when applicable, member cost sharing will be limited to in-network amounts.

3. The duration of time will be determined on a case-by-case basis taking into consideration the members individual circumstances and availability to in-network providers.

4. Requests based on member preference only or a past healthcare history with a non-participating provider, in the absence of a covered, specific medical need that cannot be met by the Plan's participating providers are subject to the contractual limitations and exclusions or exceptions as set forth in Plan Benefit Guidelines.

V. DEFINITIONS

   **Active Course of Treatment**: Typically involves regular visits with a practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment plan.

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

   **Chronic Condition**: A medical condition due to disease, illness, or other medical or mental health problem or 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.

   **Continuity of Care**: A process for assuring that care is delivered seamlessly across a multitude of delivery sites and transitions in care throughout the course of the disease process (NCQA).

   **Participating Provider**: For the purposes of this policy, participating provider refers to providers in-network with JHHC Plans.

VI. BACKGROUND

   Continuity of Care is a health plan process that, under certain circumstances, provides new members with continued care with a former, non-participating provider, including general acute hospitals, while transitioning to a participating provider. It also applies to existing members impacted by a participating provider termination.

   The Annotated Code of Maryland § 15-140 identifies health plan requirements regarding continuity of care to protect members from harmful disruptions in health care services and promote reasonable continuity of health care when transitioning between applicable health plans. Refer to: [Annotated Code of Maryland § 15-140](#).
The National Committee for Quality Assurance (NCQA) dictates standards for network management which include notification to members impacted by network provider terminations as well as requirements to assist members with the selection of a new practitioner. Continued access to practitioners is also addressed in this NCQA standard which requires accredited health plans to allow members to continue treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. This time period is extended for members in their second or third trimester of pregnancy, and continuation of care is required through the post-partum period (NCQA NET 5 A and B 1, 2).

VII. CODING DISCLAIMER

CPT Copyright 2018 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Note ~ The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member’s specific benefit plan determines coverage and referral requirements. All inpatient admissions require preauthorization.

Compliance with the provision in this policy may be monitored and addressed through post payment data analysis and/or medical review audits

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<tr>
<td>Employer Health Programs (EHP) refer to specific Summary Plan Description (SPD). If there is no criteria in the SPD, apply the Medical Policy criteria.</td>
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<td>Priority Partners (PPMCO) refer to COMAR guidelines and PPMCO SPD then apply the Medical Policy criteria.</td>
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<tr>
<td>US Family Health Plan (USFHP), TRICARE Medical Policy supersedes JHHC Medical Policy. If there is no Policy in TRICARE, apply the Medical Policy Criteria.</td>
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<tr>
<td>Advantage MD, LCD and NCD Medical Policy supersedes JHHC Medical Policy. If there is no LCD or NCD, apply the Medical Policy Criteria.</td>
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VIII. CODING INFORMATION

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IX. REFERENCE STATEMENT

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins HealthCare LLC (JHHC) Medical Policy Team during the development and implementation of this medical policy. Per NCQA standards,
the Medical Policy Team will continue to monitor and review any newly published clinical evidence and adjust the references below accordingly if deemed necessary.

X. REFERENCES


Code of Maryland Regulations. COMAR 31.10.42.01-04. Title 31, Maryland Insurance Administration. Continuity of Health Care Notice. Retrieved: www.dsd.state.md.us/COMAR.


Maryland MCO System Performance Standards and Guidelines, Standard 8.7.


XI. APPROVALS

Historic Effective Dates: 12/02/2016