KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria

Transition of Care

- Continuing Care with Terminated Practitioners
- Continuing Care with Providers outside of the Member's KPWA Health Plan Network for new enrollees

Medicare

Manuals

Chapter 4 – Benefits and Beneficiary Protections – 110.1.2 Significant Changes to Networks

Criteria

I. This policy applies to **Medicare Advantage Members and only HMO Members* that are receiving outpatient care**

A. Continued coverage with a non-network provider may be covered when **All of the following** criteria are met:

1. The most recent documentation of care provided by the treating practitioner/clinic must be provided and support need for ongoing care.
2. Discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes based on clinical notes and reviewer's clinical judgment.
3. The member is undergoing an active** course of treatment for a chronic or acute medical condition with this requested provider. In this circumstance, the member will be permitted to receive coverage until the acute phase is resolved or up to 90 calendar days or, whichever is shorter.

B. Has a qualifying situation that in the Kaiser Permanente Medical Director judgment would place the patient's current health status at risk if care is transitioned from the current provider.

1. Examples of qualifying situations may include but are not limited to:
   - The member is in their second or third trimester of pregnancy. In this case, the member will be permitted to receive continued coverage with her previously established obstetric provider for the remainder of her pregnancy through the postpartum period (six weeks after the delivery date).
   - In a course of chemotherapy or radiation therapy (initiation of a second course with a different chemotherapy agent can be transitioned to a new provider)
   - Receiving outpatient intravenous therapy for a resolving condition (e.g. antibiotics for infection) until the condition is resolved or up to 6 weeks; whichever is shorter.
   - In the process of staged surgical procedure, where the stages will be completed within 60 days.
   - Receiving Outpatient or Intensive Outpatient (IOP) treatment for chemical dependency or substance use disorders, and in the program of care for greater than 2 weeks. If approved, Transition Care may be approved for no more than 60 days.
   - Receiving Acute Residential or Partial Hospital treatment for chemical dependency or substance use disorders, and in the program of care for greater than 1 week. If approved, Transition Care may be approved for no more than 30 days.
   - Outpatient Mental Health services where time is required to transition to an in-network provider. If approved, Transition Care may be approved for no more than 3 visits within 30 days.
   - Post-operative period (no more than 90 days)
   - Inpatient hospitalization where the discharge is expected to occur in 2 days. Longer stays for medically stable patients may be transferred to a contracted facility.

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- Specialty services where time is required to transition to an in-network provider (one visit)
- Transplant patient already listed at a non-preferred hospital, may stay until transplant occurs
- Post acute non-operative fracture care (no more than 90 days)

C. Does not have one of the situations below that will be redirected to an in-network provider:
   1. Scheduled elective procedure following enrollment to a Kaiser Permanente plan
   2. Physical examination
   3. Elective service and procedures
   4. Second opinion evaluations
   5. Home care services
   6. Routine monitoring of a chronic condition

D. Has completed a Transition of Care request form within 30 days of enrollment in a Kaiser Permanente plan (only required for new enrollees).

* This policy does not apply to Access PPO or POS members as they will utilize their OON benefit for continuing care

** An active course of treatment is defined as a program of planned services to correct or treat a diagnosed condition for a defined number of services or treatment period until care is completed or a transfer of care with relevant clinical information required to ensure continuity can be initiated.

The above criteria do not include routine monitoring for a chronic condition.

> The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, KPWA will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Transition of Care for New Enrollees: The criteria were developed to promote consistency in identifying the clinical situations where the practitioner may continue to provide care for a Kaiser Permanente enrollee for the time required to complete the course of treatment. Kaiser Permanente will assist members in planning for continued care in selected case-specific situations where the member is changing from another health plan to a Kaiser Permanente plan.

Terminated Providers: When a practitioner is ending his/her contract with Kaiser Permanente, care must be safely transitioned or transferred to another Kaiser Permanente contracted or Kaiser Permanente practitioner in the same or similar specialty. When the Kaiser Permanente member is in an active course of treatment, the transition to a contracted or Kaiser Permanente practitioner of the same or similar specialty may be delayed until treatment has been completed.

The criteria assume that the contract termination with the provider was not based on a professional review action and that the provider is remaining in the local area and is not retired.

Date Created	Date Reviewed	Date Last Revised
12/19/2001	07/6/2010[MDCRPC], 05/03/2011[MDCRPC], 03/06/2012[MDCRPC], 01/08/2013[MDCRPC], 11/05/2013[MPC], 09/02/2014[MPC], 08/04/2015[MPC], 06/07/2016[MPC], 04/04/2017[MPC], 02/06/2018[MPC], 11/06/2018[MPC]	04/04/2017

[MDCRPC] Medical Director Clinical Review and Policy Committee
[MPC] Medical Policy Committee

Revision History	Description
08/04/2015	MPC approved to merge policies to speak to continued coverage with a non-network provider. It is compliant with NCQA and Medicare regulations for transition of care.
01/11/2016	Added Medicare link
02/07/2017	MPC approved to adopt minor changes to criteria to specify **Outpatient** Mental Health Services & approval for no more than **3 visits** within 30 days.
04/04/2017	Added indication to clarify this policy only applies to HMO members receiving outpatient care

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