KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Continuity of Care

- Request for Continuing Care with Terminated Providers for existing enrollees

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	Chapter 4 – Benefits and Beneficiary Protections – 110.1.2 Significant Changes to Networks *… it may be necessary for MAOs to allow care to continue to be furnished on an interim, transitional basis, by providers who have been terminated from the network in order to adequately address continuity of care needs for affected enrollees.* *Please note that CMS considers "enrollees who are patients seen on a regular basis by the provider whose contract is terminating" to be "affected enrollees." An "affected enrollee" as an enrollee who is assigned to, currently receiving care from, or has received care within the past three months from a provider or facility being terminated.* Please see Kaiser Permanente Non-Medicare criteria below for more detail.
Standard Memo	Kaiser Permanente submits this standard memo language to CMS to address continuity of care when there is a network reduction: **SPECIALTY CARE** KFHPWA members in active treatment affected by the network changes will continue to receive covered health care services from their current providers who are being removed from the Medicare Advantage networks. Additionally, current authorizations to providers being removed from the Medicare Advantage networks will be honored. For members in a specific course of treatment, continued care will be authorized without interruption until such authorization is completed. KFHPWA has a transition of care policy that is clinically based, and member concerns will be evaluated and addressed individually by KFHPWA's review services and clinical review staff to ensure members continue to receive appropriate care. **PRIMARY CARE** Members paneled to <<group-providers being eliminated CLINIC/GROUP NAME>> primary care providers will be provided access to their provider for up to 60 days following a written notice

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	offering the member a selection of new personal physicians from which to choose. Any members in active treatment affected by the network changes will continue to receive covered health care services from their current providers who are being removed from the Medicare Advantage network. Additionally, current authorizations to providers being removed from the Medicare Advantage network will be honored. For members in a specific course of treatment, continued care will be authorized without interruption until such authorization is completed. KFHPWA has a transition of care policy that is clinically-based, and member concerns will be evaluated and addressed individually by KFHPWA's review services and clinical review staff to ensure that members continue to receive appropriate care.

For Non-Medicare Members

I. This policy applies to current Kaiser Permanente members with Commercial plans (HMO, PPO, and POS) as well as Medicare Advantage members receiving ongoing primary care or specialty care services. **This does not apply to new enrollees to Kaiser.**
   - Examples of continuing specialty care services include, but are not limited to:
     - outpatient care;
     - inpatient care; or
     - scheduled non-elective surgeries.

II. Continued coverage is required when:
   - Termination of the provider contract by the health plan or by the provider
   - Provider remains contracted but whose services are no longer needed for a specific item/service or provider ceases to perform a specific item/service

III. Continuity of care for primary care providers (PCPs) applies to members paneled with the terminating PCP or who have received care within the last 6 months (based on claims)**.** The duration is for up to 90 calendar days from receipt of the notification of the contract change.

IV. Ongoing specialty care may be covered for members:
   1. Members who have an open authorization to the terminating provider *OR*
   2. Members who have received care from the terminating provider within the last 12 months (based on claims) when **ALL of the following** criteria are met:
      - The most recent documentation of care provided by the treating practitioner/clinic must be provided and support need for ongoing care.
      - 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.
      - The member is undergoing continuing care for an **active course of treatment**** for a chronic or acute medical condition with this requested provider (not for a new episode of care). In this circumstance, the member will be permitted to receive coverage until the need for continuing care is resolved or up to 90 calendar days from receipt of the notification of the contract change, whichever is shorter.

V. This does not apply to new Kaiser Permanente enrollees. Please refer to the Transition of Care Coverage Guidelines for more information on transferring care for new Kaiser Permanente members &/or Transition of Care Clinical Criteria.

Continuity of Care Examples:

Examples of qualifying continuity of care scenarios may include, but are not limited to:

- Pregnancy related services:
- The member is at 28 weeks or beyond in their pregnancy at the time they are notified of their current provider's change in network status. In this case, the member will be permitted to receive continued coverage with their previously established obstetric provider for the remainder of their pregnancy through the postpartum period (six weeks after the delivery date).
  - In a course of chemotherapy or radiation therapy, until the course is completed or not to exceed 90 days from the time they are notified of their current provider's change in network status

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- Receiving outpatient intravenous therapy for a resolving condition (e.g., antibiotics for infection) until the condition is resolved or up to 90 days from the time they are notified of their current provider's change in network status, whichever is shorter.
- In the process of staged surgical procedure, where the next stage(s) will be completed within 90 days from the time they are notified of their current provider's change in network status when medically necessary.
- Receiving Outpatient or Intensive Outpatient (IOP) treatment for chemical dependency or substance use disorders. Transition Care may be approved until the clinical course is completed or for no more than 90 days from the time they are notified of their current provider's change in network status when medically necessary.
- Receiving Acute Residential or Partial Hospital treatment for chemical dependency or substance use disorders. Transition Care may be approved until the clinical course is completed for no more than 90 days from the time they are notified of their current provider's change in network status when medically necessary.
- 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 90 days from the time they are notified of their current provider's change in network status.
- Post-operative period (no more than 90 days).
- Inpatient hospitalization (no more than 90 days from the time they are notified of their current provider's change in network status). Longer stays for medically stable patients may be transferred to a contracted facility.
- Rehabilitative care, such as physical therapy, occupational therapy, speech therapy, and/or massage therapy until the acute condition is resolved or where time is required to transition to an in-network provider (no more than 90 days from the time they are notified of their current provider's change in network status).
- Post-acute non-operative fracture care (no more than 90 days).

Examples of the situations below that **do not** qualify for continuity of care include, but are not limited to:

- Physical examinations
- Elective service and procedures
- Second opinion evaluations
- Home care services
- Routine monitoring of a chronic condition
- Specialty evaluation/assessment for a new clinical concern

Definitions:

- **Active Course of Treatment:** 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.
- **Continuing Care Patient*:**
  - A member who is:
    - undergoing a course of treatment for a serious and complex condition from the provider or facility; undergoing a course of institutional or inpatient care from the provider or facility;
    - scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
    - pregnant and undergoing a course of treatment for the pregnancy from the provider or facility, or
    - is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.
- **Serious and Complex Condition*:**
  - A member that has:
    - in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
    - in the case of a chronic illness or condition, a condition that is:
      - life-threatening, degenerative, potentially disabling, or congenital; and
      - requires specialized medical care over a prolonged period of time.

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Federal: 26 U.S.C.A. § 9818; 29 § USC 1185g; 42 USC 300gg-113*
State: WAC 284-170-280(f)(i)(J); WAC 284-170-360(7); RCW 48.43.515

Date Created	Date Reviewed	Date Last Revised
11/06/2021	12/07/2021[MPC],	05/04/2022

[MPC] Medical Policy Committee

Revision History	Description
12/07/2021	MPC approved to adopt a new policy to support federal legislation related to continuity of care for existing KP members in HR 133 Consolidated Appropriations Act. This policy holds specific requirements at the federal level for commercial plans when providers term or when a plan terms a provider from the provider network.
05/04/2022	Updated specialty claims lookback timeframe from 6 months to 12 months.

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