KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Transition of Care

- Requests by new enrollees for continuing care with Providers outside of the member's Kaiser Permanente Health Plan Network
- Continuing inpatient coverage for terminating Kaiser members while currently hospitalized

Criteria

No Washington State RCW or WAC applies to new members joining Kaiser Permanente, in reference to transition of care.

This document applies to members who are inpatient status at the time of enrollment or at the time of disenrollment***

This document does not apply to existing KPWA members whose provider's contract has been terminated – see Continuity of Care Policy

Line of Business	Criteria
Medicare Members	The ***transition of care clinical criteria*** is intended to prevent disruption of an already initiated treatment plan. For the purpose of this policy, a treatment plan is considered already initiated when the member is receiving the service or has already been scheduled to receive that service. Similarly, a consultation is considered already initiated when it has been scheduled. When a consultation has occurred or is scheduled to occur, for the purpose of considering a particular service, that service shall not be considered initiated if it has not yet been provided or scheduled at the time that the members new Medicare Advantage policy becomes active. A. Continued coverage for new Medicare Advantage enrollees with a non-network provider may be covered of the health plan when **all of the following** criteria are met: 1. Has completed a Transition of Care request form within 90 days of enrollment in a Kaiser Permanente plan (only required for new enrollees). 2. The most recent documentation of care provided by the treating practitioner/clinic outlines the need for ongoing care related to an active** course of treatment. 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 may be permitted to receive coverage until the acute phase is resolved or up to 90 days whichever is shorter. 4. Discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes, based on clinical notes and KPWA Medical Director's clinical judgment. B. ***Members currently in the hospital when ***joining*** KPWA 1. See the following links for Codes of Regulations:

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	• *42 CFR § 422.318 Special rules for coverage that begins or ends during an inpatient hospital stay.* • *42 CFR § 422.320 Special rules for hospice care.* C. **Outpatient Prescription Drugs** Within 90 days of enrollment, members may fill up to a 30-day supply of medication, including nonformulary drugs and with waiver of Kaiser Permanente's step therapy and prior authorization requirements. This 30-day supply does not include excluded drugs and specialty products and does not override quantity limits that are in the place for quality or safety reasons. ***Active course of treatment: a patient is actively seeing a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.*
Non-Medicare Members	A. Continued coverage for new and termed enrollees with a non-network provider may be covered ***at the discretion*** of the health plan when **all of the following** criteria are met: 1. Has completed a Transition of Care request form within 30 days of enrollment in a Kaiser Permanente plan (only required for new enrollees). 2. The most recent documentation of care provided by the treating practitioner/clinic must be provided and support need for ongoing care. 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 may be permitted to receive coverage until the acute phase is resolved or up to 30 days whichever is shorter. 4. Discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes, based on clinical notes and KPWA Medical Director's clinical judgment. 5. The above indications (1-4) are not applicable to PPO and POS members who may continue to see former providers using their out-of-network benefit. B. ***Members currently in the hospital when ***joining*** KPWA** 1. The hospital stay prior to joining KPWA is the financial responsibility of the prior insurance or the patient. 2. KPWA will cover medically necessary hospital stays starting day of enrollment 3. At KPWA discretion, patient may be transferred to in-network hospital C. ***Members currently in the hospital when ***terminating*** KPWA Coverage** Continuation of Inpatient Services: Members who are receiving covered services past their health plan termination date will no longer be covered. Members will be responsible for all charges incurred. D. As an exception, pregnancy related services: If the member is at 32 weeks or beyond in their pregnancy at the time of their enrollment with Kaiser Permanente. 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). E. **Outpatient Prescription Drugs** Within 90 days of enrollment, members may fill up to a 30-day supply of medication, including nonformulary drugs and with waiver of Kaiser Permanente's step therapy and prior authorization requirements. This 30-day supply does not include excluded drugs and specialty products and does not override quantity limits that are in the place for quality or safety reasons. ***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*

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	until care is completed or a transfer of care with relevant clinical information required to ensure continuity can be initiated. The following situations will be directed 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 **Note:** 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, Kaiser Permanente 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.

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], 11/05/2019[MPC], 11/03/2020[MPC], 11/02/2021[MPC], 11/01/2022[MPC], 11/07/2023[MPC]	01/09/2024

[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
04/07/2020	Added additional language per WAC 284-170-360, regarding continuing primary care for Access PPO and POS members when a network provider is termed with no cause.
01/05/2021	MPC approved the changes related to Pregnancy services to include the member is at 32 weeks or beyond in their pregnancy at the time of their enrollment with Kaiser Permanente or at the time their provider changes network status. Requires 60-day notice, effective date 06/01/2021.
02/01/2022	MPC approved updates to the Transition of Care Policy that is specific for members who are new enrollees for continuing care with Providers outside of the member's Kaiser Permanente Health Plan Network and as well as guidance on continuing inpatient coverage for terminating Kaiser members while currently hospitalized.
11/11/2022	Updated Criteria to reflect the EOC language effective 01/01/2023.
10/01/2023	MPC approved changes to clinical criteria in efforts to comply with CMS 2024 Final Rule for Medicare and Non-Medicare; Effective January 1, 2024.
01/09/2024	Added *termed* enrollees to ensure the policy applies to members whose coverage was terminated due to their employer ending the contract.

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