Cigna

Policy Name Transition of Care Service Requests For New Customers		Policy Number UM-35
Business Segment Healthcare		
Initial Effective Date: 09/01/00	**Policy Committee Approval Date(s):** 5/11/21; 4/12/22; 3/28/23; 4/25/23; 4/23/24	
Replaces Policies: CGMM-III-10 Transition of Care Services for New Customers UM-US-052 Transition of Care		

Purpose:
The purpose of this policy is to establish a consistent process for evaluating and responding to Transition of Care requests for new enrollees.

Policy Statement:
Transition of Care (TOC) refers to the process of transitioning medical care for new enrollees from non-participating providers to participating providers. The TOC process evaluates requests for authorization and reimbursement of a non-participating provider at the in-network level of benefits for services that would be considered covered benefits when provided by a participating provider. In so doing, the TOC process evaluates clinical contraindications for the immediate transfer of a customer from a non-participating provider to a participating provider including conditions where the transfer of care is not permitted per accreditation standards, regulatory or state requirements, could cause worsening of the condition, reoccurrence, or interfere with anticipated outcomes.

A new enrollee is defined as a new Cigna Healthcare customer or an existing Cigna Healthcare customer enrolled into a new medical product (i.e. change in benefit plan).

A Transition of Care Request Form is required to evaluate services for TOC coverage and should be submitted no later than 30 calendar days following the effective date of enrollment. However, a 30 day grace period allows requests received 60 days following the customer's new enrollment date. Services eligible for TOC are subject to benefit plan limitations and end when the one of the following occurs:

- Care for the acute and/or chronic condition is completed;
- Care is successfully transitioned to a participating provider;
- Benefit limitations are exceeded;
- Time period approved for TOC coverage is exceeded

Approvals and adverse determinations are provided in writing to the requester/designee. With adverse determinations, customers are advised of their right to appeal and the process for initiating an appeal.

Review for medical necessity will not be performed for Ancillary Services Transition of Care requests except in specific states as noted in the State Compliance section and/or services provided by a licensed practitioner. An administrative denial letter is sent to the customer and/or requesting provider.

For purposes of this policy, the definition of an ancillary provider is a provider or facility of auxiliary or supplemental services used to support diagnosis and treatment of a condition. These providers include but are not limited to:

- Acupuncture
- Ambulance/transportation services
- Custodial care services (only when a covered benefit)
- Diagnostic services, miscellaneous (e.g. EMG, neuropsychological testing, etc.)
- Dietary services including dieticians, nutritionists, and nutritional support services
- Durable medical equipment (DME)
- Health education services
- Hearing aids
- Home health services
- Imaging services
- Infusion centers
- Laboratory services
- Licensed Midwife working independently and not billing under an OB/GYN (unless otherwise specified by state mandates)
- Nurse Surgical Assistant
- Orthotics and prosthetics
- Outpatient cardiac rehabilitation
- Outpatient surgery centers
- Pharmacy services
- Physician extenders including physician assistants, nurse practitioners, clinical nurse specialists
- Sleep disorder studies

Individual Family Plans (IFPs) - As Individual and Family Plan (IFP) customers have freedom to choose any plan and have access to the provider directory during their enrollment period, in the absence of applicable state mandates transition of care (TOC) generally does not apply. A TOC exception may, however, be granted when transitioning to an In-Network provider is impossible or will result in an imminent and significant threat to the health and well-being of the customer, as determined by the Cigna Medical Director.

Definitions:
For purposes of this policy "customer" means an individual participant or member.

COC: Continuity of Care (COC) refers to the continuation of medical care for customers when a participating provider (may be physician, ancillary and/or facility) leaves the network and ongoing medical care/services are requested as outlined in policy UM-41.

State/Federal Compliance:
This list is not all inclusive; please refer to iComply for entire listing of state specific requirements

- For California HMO, the timeline for completion of TOC requests is 5 business days from receipt of all required information to customer/provider notification.
- Medical Necessity reviews for ancillary services/providers for Transition of Care will be performed by a physician reviewer in the following states for customers who are enrolled in non-ASO products unless other noted: California (applies to Network-ASO members who reside in CA and should be treated like CHMO enrollees in CA and covered under the CHC-CA GSA), Colorado, Connecticut, District of Columbia, Illinois, Indiana, Iowa, Louisiana, Maine, Missouri, Nebraska, New Jersey, New Mexico, North Carolina, New York, Oregon, South Dakota, Texas (applies to non-ERISA ASO) and Virginia.
- Mandated benefits may apply for several states
- Mandated turnaround times requirements may apply for several states
- Reviewer qualifications for peer review and licensing may apply for several states

NOTE: State mandates supercede Cigna Healthcare standard time periods and conditions

Procedure(s):

A. Transition of Care Request Form may be received from a customer and/or their current physician or healthcare provider. These requests are managed nationally by the Utilization Management area with the exception of the following:

- Requests for transition of behavioral health services are referred to the customer's behavioral provider
- Requests for services related to transplant and/or customers actively enrolled in Transplant Case Management are referred to the Transplant Case Manager for review

B. Time period requirements are evaluated to determine coverage.

- Requests for TOC should be submitted no later than 30 business days following effective date of enrollment. Requests are not processed until eligibility and benefits are active in the system.
- Timeline for completion of TOC requests is 8 business days, unless a stricter timeframe is required by state law, from receipt of all required information to customer/provider notification.

C. The customer's condition is evaluated by a nurse to determine coverage. The nurse will request a brief history, treatment plan and/or current evaluation if needed to determine TOC coverage. When reasonably necessary clinical information is not provided, the request is pended for additional information based on the Lack of Information (LOI) policy.

D. Unless otherwise addressed by a state mandate, acute and/or chronic conditions in active treatment which may be approved as TOC are defined as any of the following:

- physician visit or hospitalization;
- documented changes in a therapeutic regimen within 21 days prior to the effective date of enrollment;
- conditions where discontinuity could cause worsening of the condition, reoccurrence and/or interference with anticipated outcomes

E. Unless otherwise addressed by a state mandate, the below TOC requests may be approved for reimbursement of a non-participating provider at an in-network benefit level for up to 90 calendar days.

- Terminal conditions
- Acute and/or chronic conditions in active treatment
- 2nd and 3rd trimester of pregnancy including post-partum care
- Hospital confinement on the plan effective date for plans which do not have extension of benefit provisions

NOTE: Elective surgeries scheduled more than 21 days preceding eligibility AND within 2 weeks of the plan effective date will be reviewed on a case-by-case basis by the Medical Director to ensure continuation in quality of care.

F. Non-participating facility services associated with a TOC request may be approved for in-network reimbursement for a service that qualifies for coverage under TOC when the physician does not have privileges at a participating facility offering those services.

G. Approved requests to cover services provided by a non-participating provider at the in-network benefit level will include the following:

- List of the specific services approved
- Specified time period services are approved *(not to exceed 90 calendar days with the exception of pregnancy or approval by Medical Director)*

H. Requests which cannot be approved by the nurse are referred to the Medical Director for determination. The Medical Director reviews the treating provider's treatment plan to assess the individual health care needs of the customer and ensure a reasonable transition period to continue his/her course of treatment. Exceptions may be made on a case-by-case basis to authorize periods longer than the standard 90 calendar days to preserve continuity of care for a defined and limited treatment interval (e.g., a chemotherapy treatment plan that is expected to be completed within 120 days).

I. The Medical Director will complete the required documentation and will forward to the appropriate staff for recording in UM system and customer and/or provider notification.

J. Coverage determination letter is sent to the customer and/or requesting provider. An adverse determination will include the rationale for the decision and guidance on obtaining information on participating providers as well as advised of their right to appeal and the process for initiating an appeal

Applicable Enterprise Privacy Policies:
https://iris.cigna.com/business_units/legal_department/enterprise_compliance/privacy/privacy_policies

Related Policies and Procedures:
Adverse Determination Notification Elements Policy UM-13
Timeliness of Health Services Decisions Policy UM -39
Interact and Medical Director Case Review Policy UM-08
Network Adequacy Provision (NAP) Policy UM-20
Pre-Certification of Inpatient, Outpatient and Ambulatory Services Policy UM-09

Links/PDFs:
Attachment 1: States with Transition of Care Laws that Deviate From Cigna Standard Process
Attachment 2: States with Transition of Care Laws that Do Not Deviate from Cigna Standard Proc

STATES WITH TRANSITION OF CARE LAWS THAT DEVIATE FROM
(ARE RICHER THAN) Cigna STANDARD PROCESS

ATTACHMENT 1: Last reviewed January 2020

State	Timeframe and Conditions Eligible for Transition of Care (TOC)	Deviation from Cigna Standard Process
TOC period = 90 days from effective date Customer/provider must submit request within 60 days from effective date. • Terminal conditions • Acute conditions in active treatment • 2nd or 3rd trimesters of pregnancy and postpartum care • Facility services for inpatient care, maternity and hospice when non-par provider services are approved and the provider does not have privileges at par facility.		
California TOC mandate s apply to: HMO/Network (CA residents) EPO/OAPINN And ASO members who reside in CA. (These members are treated like CHMO enrollees in CA and covered under the	• Medical Necessity reviews for ancillary services/providers for Transition of Care will be performed by a physician reviewer • No timeframe for receipt of requests (cannot deny for submitting the request after sixty days) • TOC must be provided for: • An **acute condition**, for the duration of the acute condition. An "acute condition" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. • A **serious chronic condition**, for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Cigna Medical Director (or designee) in consultation with the enrollee and treating provider, consistent with good professional practice. This period shall not exceed 12 months from the provider's	• Must provide TOC for acute condition for duration of condition (may exceed 90 days) • Must provide TOC for serious chronic conditions up to 12 months • TOC for pregnancy may begin during 1st trimester- for the duration of the pregnancy and the immediate post partum period • TOC for newborns age birth – 36

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CHC-CA GSA). A new enrollee is defined as a new Cigna Healthcare customer or an existing Cigna Healthcare customer enrolled into a new medical product (i.e. change in benefit plan) or network.	termination date or the effective date of coverage for the newly covered enrollee. A "serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical 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. • A **pregnancy**, for the duration of the pregnancy (three trimesters) and the immediate postpartum period. • Maternal Mental Health condition later of 12 months from the diagnosis or 12 months from the end of the pregnancy • A **terminal illness**, for the duration of the terminal illness. A "terminal illness" is an incurable or irreversible condition that has a high probability of causing death within one year or less. • **Care of a newborn child whose age is between birth and age 36 months**, regardless of whether the child is undergoing an active course of treatment, for a period not to exceed 12 months. • **Performance of surgery or other procedure that has been authorized by the plan,** as part of a documented course of treatment that is to occur within 180 days of the provider's termination date or the effective date of coverage for a newly covered employee • TOC coverage is provided based on condition and therefore all request must be reviewed for medical necessity of the customer with a condition described above. This includes requests for ancillary services.	months, up to 12 months of TOC coverage • Possible TOC for pre-approved surgery/procedure • Maternal Mental Health for the later of 12 months from the diagnosis or 12 months from the end of pregnancy

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State	Timeframe and Conditions Eligible for Transition of Care (TOC)	Deviation from Cigna Standard Process
	• NOTE: In relation to groups delegated for Utilization management, review for TOC is NOT delegated and remains the responsibility of Cigna. Cigna will coordinate the outcome of the review with the applicable provider group.	
Connecticut	• Where Cigna plan replaces other coverage and covers services related to hospital confinement and/or total disability, period of transitional care must be "clinically appropriate" for the customer's medical condition.	• No specific time limit on transition of care when the customer is hospital confined or is totally disabled. • Transition period must be “clinically appropriate” for customer’s condition.
Maine	• At least 60 days of TOC • Pregnancy through postpartum care	• Must provide TOC coverage for *at least* 60 days

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State	Timeframe and Conditions Eligible for Transition of Care (TOC)	Deviation from Cigna Standard Process
Massachusetts	• At least 30 days of TOC • Pregnancy including first postpartum visit • Until participant's death if terminally ill	• Must provide TOC coverage for terminal illness until participant's death – no time limit • Must provide TOC coverage for *at least* 30 days
Minnesota	• Up to 120 days TOC for acute conditions and pregnancy beyond 1st trimester • For rest of participant's life if life expectancy is 180 days or less (or, up to 180 days max TOC) • Allows same TOC for customers receiving culturally appropriate services or who do not speak English and there is no new provider in the network that can provide these services	• Must allow 120 days of TOC, timeframe may be extended if medically necessary • Must provide TOC for terminal illness for up to 180 days (if life expectancy is 180 days or less) • Must allow TOC from 1st trimester of pregnancy • Must allow TOC for customers receiving culturally appropriate services or who do not speak English (provided there is no comparable provider in-network)

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State	Timeframe and Conditions Eligible for Transition of Care (TOC)	Deviation from Cigna Standard Process
New Jersey	For new enrollees, Cigna must accept prior carrier's authorization for care from Cigna non-participating providers. Coverage may be subject to the customer's new Cigna plan, including benefit plan limits, provider network access (e.g. if lock in product, must see par provider), cost sharing INN vs. OON if customer is seeing a non-par provider, must pay OON, etc.	• Must accept prior carrier's authorization for care from Cigna non-participating providers subject the Cigna plan's coverage provisions.

STATES WITH TRANSITION OF CARE LAWS THAT DEVIATE FROM (ARE RICHER THAN) Cigna STANDARD PROCESS

ATTACHMENT 1: Last reviewed January 2020

State	Timeframe and Conditions Eligible for Transition of Care (TOC)	Deviation from Cigna Standard Process
New Mexico	• Not less than 30 days TOC • Pregnancy through postpartum care	• Must provide TOC coverage for *at least* 30 days

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State	Timeframe and Conditions Eligible for Transition of Care (TOC)	Deviation from Cigna Standard Process
New York	• Up to 60 days TOC • Pregnancy through postpartum care	• Standard meets state requirements, except that appeals must be handled under the terms of the NY Administrative Appeal P&P for fully insured customers **NOTE: NY has laws which govern referral/auth of care for customers with life-threatening or degenerative or disabling conditions, to avoid improper denials of non-par care. See CI titled, "Provider Referrals: Referrals" for details.**

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State	Timeframe and Conditions Eligible for Transition of Care (TOC)	Deviation from Cigna Standard Process
North Carolina	• Up to 90 days TOC (including pregnancy from 2nd trimester) • Until customer's death if terminally ill • Pregnancy- if insured entered second trimester on date of enrollment in new plan, and provider was treating the pregnancy before the date of notice, the transitional period shall extend through 60 days of postpartum careIf surgery, organ transplantation, or inpatient care was scheduled before the time of enrollment in a new plan, or the customer was on an established waiting list, the transitional period shall extend beyond the general transition period through the date of discharge of the individual after completion	• Must provide TOC for terminal illness until participant's death – no time limit • Newly insured has 45 days of the insured's date of enrollment to notify the plan they elect to continue treatment by the provider • Pregnancy- transition shall extend for 60 days of post partum care • Pre-scheduled surgeries should be approved through the date of discharge
Texas	• No law	• Appeals must be handled under the terms of the TX Administrative Complaint & Appeals P&P for fully insured customers

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State	Timeframe and Conditions Eligible for Transition of Care (TOC)	Deviation from Cigna Standard Process
Washington	• For PCPs, at least 60 days or for plans with open enrollment periods, until the end of the next open enrollment period	• For PCPs, at least 60 days or for plans with open enrollment periods for selection of new PCPs, until the end of the next open enrollment period • For all other providers, follow Cigna standard.

STATES WITH TRANSITION OF CARE LAWS THAT DO NOT DEVIATE FROM
Cigna STANDARD PROCESS

ATTACHMENT 2: Last reviewed January 2020

STATE	TRANSITION OF CARE (TOC) REQUIREMENTS
Cigna Standard	TOC period = 90 days from effective date Customer/provider must submit request within 45 days from effective date. • Terminal conditions • Acute conditions in active treatment • 2nd or 3rd trimesters of pregnancy and postpartum care • Active engagement in acute inpatient rehab program for a condition with a new onset within the 21 days preceding eligibility. Coverage is subject to therapy limitations under benefit plan including Physical Therapy, Occupational Therapy, Speech Therapy and chiropractic care. • Facility services for inpatient care, maternity and hospice when non-par provider services are approved and the provider does not have privileges at par facility.
Arizona	• 30 days TOC for life threatening condition • Up to 6 weeks after delivery
Arkansas	• Until treatment ends • Up to 90 days TOC
Illinois	• Up to 90 days TOC • Pregnancy including postpartum care

STATES WITH TRANSITION OF CARE LAWS THAT DO NOT DEVIATE FROM
Cigna STANDARD PROCESS

ATTACHMENT 2: Last reviewed January 2020

Iowa	• Up to 90 days • Pregnancy through postpartum care
Missouri *(law is HMO only)*	• Up to 90 days TOC
Montana	• Up to 90 days TOC • Pregnancy second or third trimester through postpartum care
Pennsylvania	• Up to 60 days TOC • Pregnancy through postpartum care
Vermont	• Up to 60 days TOC (or until TOC to new provider) • Pregnancy through postpartum care

States without TOC laws:
Alabama, Alaska, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virgin Islands, Virginia, West Virginia, Wisconsin, and Wyoming