Cigna

Policy Name Continuity of Care Service Requests		Policy Number UM-41
Business Segment HealthCare		
Initial Effective Date: 03/1998	**Policy Committee Approval Date(s):** 5/11/21; 12/14/21; 4/12/22; 3/28/23; 4/25/23; 9/26/23; 4/23/24	
Replaces Policies: CGMM-III-17 Continuity of Care Services When a Provider or Facility Terminates		

Purpose:
The purpose of this policy is to establish a consistent process for evaluating and responding to Continuity of Care requests when a Cigna participating health care provider or facility leaves the network or, in limited circumstances, when a client terminates its contract with Cigna.

Policy Statement:
Continuity of Care (COC) refers to the continuation of care for customers when:

- A participating health care professional (may be physician, ancillary and/or facility) leaves the network and ongoing medical care/services are requested
- Benefits under the ASO plan or health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the provider or facility's network participation (e.g., provider no longer contracts to participate in the OAP network but continues to participate in the PPO network)
- A fully insured client terminates their insurance policy with Cigna and the client's replacement group health coverage does not include access to the health care professional at the new plan's in-network level and ongoing medical care/services are requested

The COC process validates that the customer requesting continuity of care is a continuing care patient with a serious and complex medical condition.

Customers are notified of health care provider or facility terminations, and their right to elect continued care on a timely basis via several avenues initiated by Provider Services Contracting and/or Regional Network Management.

*Customers are notified of client contract terminations with Cigna by their employer or plan sponsor.

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

TOC: Transition of Care (TOC) refers to the process of transitioning medical care for new enrollees from non-participating health care professionals to participating health care professionals as outlined in policy UM-35.

Continuing Patient Care is an individual who is:

- undergoing a course of institutional or inpatient care from the terminating provider or facility

- undergoing a course of treatment for a serious and complex condition from the terminating provider or facility
- scheduled to undergo non-elective surgery from the terminating provider or facility, including postoperative care from the terminating provider or facility with respect to such surgery;
- pregnant and undergoing a course of treatment for the pregnancy from the terminating provider or facility or
- determined to be terminally ill and is receiving treatment for such illness from the terminating provider or facility

A serious & complex condition is:

- an acute illness or condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm;
- a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolong period of time

Cigna Pathwell Specialty:

- Certain Medical Pharmaceuticals that are used for treatment of complex chronic conditions, are high cost, and are administered and handled in a specialized manner may be subject to additional coverage criteria or require administration by a participating provider in the network for Cigna Pathwell Specialty. Cigna determines which injections, infusions, and implantable drugs are subject to these criteria and requirements.

- The network for Cigna Pathwell Specialty includes but is not limited to contracted physician offices, ambulatory infusion centers, home and outpatient hospital infusion centers, and contracted specialty pharmacies. When the network for Cigna Pathwell Specialty cannot meet the clinical needs of the customer as determined by Cigna, exceptions are considered and approved when appropriate.

State/Federal Compliance:

- Consolidated Appropriations Act/No Surprises Act §113 – 26 US Code § 9818
- Medical Necessity reviews for ancillary services/health care professionals for Continuity 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.
- The state of Maryland does not limit continuity of care to situations in which clinical contraindications exist to preclude transfer of care to a participating PCP. In other words, the enrollee only needs to request continuity of care with the terminating PCP. No medical necessity for the continuity of care with the terminating PCP needs to be demonstrated.
- 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

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NOTE: Federal/State mandates supersede Cigna standard time periods and conditions.

Procedure(s):

A. Customer Notification of Terminations (provider termination notifications in connection with a client terminating their insurance policy with Cigna are the responsibility of the client):

- Customer Notification of Provider termination: When the customer's healthcare provider is terminating and the customer has incurred one or more visits in the past six months from a terminating health care provider the customer notification includes information on the availability of COC services and the process for submitting requests. Absent an accreditation or regulatory requirement to automatically continue care, the customer will not receive COC services in the following situation:

  - provider contract discontinued based on professional review action

  Under the No Surprises Act, a customer has 90 days of COC available after receiving notice of provider termination. Calculation of the 90-day period should begin on the date notice of provider termination is provided and the customer has a full 90 days to request COC, although COC does not need to extend beyond 90 days from the date notice of provider termination is provided. A Continuity of Care Request Form is required to evaluate services for COC coverage unless a provider termination occurs without prior notice; requests will be considered on a case-by-case basis. Services eligible for COC 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 COC coverage is exceeded

- Customer Notification of Facility termination: Regional Network Management areas notifies customers of facility terminations based on historical claims data up to 18 months for that facility and/or by a designated geographic area around the facility regardless of claims history.

B. Continuity of Care Request Form may be submitted by a customer and or their current physician or provider. Requests are not processed until eligibility and benefits are active in the system. The TOC/COC team is responsible for performing the initial review & approvals. When reasonably necessary clinical information is not provided, the request is pended for additional information based on the Lack of Information (LOI) policy. If a request does not meet criteria, the case is forwarded to the Medical Director for review. Other exceptions for routing COC reviews include

- Requests for California – managed care customers are performed by the Glendale office
- Requests for continuation of behavioral health services are referred to the customer's behavioral health care carrier

- Services related to transplant and/or customers actively enrolled in Transplant Case Management are referred to the Transplant Case Manager for review

C. The customer's condition is evaluated by a nurse to determine if the request meets COC guidelines. The nurse will request a brief history, treatment plan and/or current evaluation if needed.

D. The following COC requests may be approved for reimbursement of the terminating provider at an in-network benefit level, or according to state law.
1. 90 calendar days; or
2. The date the individual is no longer a continuing care patient

- Terminal conditions
- Acute and/or chronic conditions in active treatment
- Pregnant and undergoing treatment for pregnancy including post-partum care
- Hospital confinement on the provider termination date for plans which do not have extension of benefit provisions
- Hospital confinement for either currently admitted patients or any scheduled admissions within the first 10 days from the termination date. Those scheduled beyond 10 days of the terminations are reviewed on a case-by-case basis.

NOTE: Elective surgeries scheduled more than 21 days prior to the provider's termination date AND within 2 weeks of the provider terminating will be reviewed on a case-by-case basis by the Medical Director to ensure continuation in quality of care.

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

F. 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)*

G. Requests which cannot be approved by the nurse are referred to a 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 their 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. Cigna Pathwell Specialty network, chemotherapy treatment plan that is expected to be completed within 120 days).

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

I. 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 health care professionals 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
Interact and Medical Director Case Review Policy UM-08
Timeliness of Health Services Decisions Policy UM-39
Pre-Certification of Inpatient, Outpatient and Ambulatory Services Policy UM-09
Transition of Care Service Request for New Customers UM-35
California Utilization Management Process UM-CA 11

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

State	Timeframe and Conditions Eligible for Continuity of Care	Deviation from Cigna Standard Process

Cigna Standard	COC period = 90 days from provider termination date Customer/provider must submit request within 90 calendar days of receiving notice of the provider termination date. • Terminal conditions • Acute conditions in active treatment or chronic condition requiring close medical management and frequent visits • Pregnant and undergoing treatment for pregnancy through the postpartum period (6 weeks after delivery). Facilities will be covered for maternity Cases if the provider is authorized and does not have privileges at a participating facility.	

Alaska	For longer of: • Up to 90 days • Pregnancy through completion of postpartum care • Terminally ill until end of treatment • End of current plan year	• Must provide COC for terminally ill until end of treatment – no time limit • May need to cover treatment through end of current plan year

California –All products HMO/Network (CA residents) PPO/OAP & out-of-network portion of POS plans and Network-ASO members who reside in CA. (These members are treated like CHMO enrollees in CA and covered under the CHC-CA GSA).	• Medical Necessity reviews for ancillary services/providers for Continuity of Care will be performed by a physician reviewer • No timeframe for receipt of requests (cannot deny for submitting the request after sixty days) 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. Completion of covered services will be provided for the duration of the acute condition. • 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 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. Completion of covered services will be provided for the duration of a terminal illness. • Months from the contract termination date. Page 9	• Must provide COC for acute condition for duration of condition (may exceed 90 days) • Must provide COC for serious chronic conditions up to 12 months • COC for pregnancy may begin during 1st trimester for the duration of the pregnancy and the immediate post-partum period • COC for newborns age birth – 3 up to 12 months • Possible COC 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

	• 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 • **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. • **COC coverage** is provided based on condition and therefore all required requests must be reviewed for medical necessity if the customer has a condition described above. This includes requests for ancillary services NOTE: In relation to medical groups capitated for healthcare services and delegated for Utilization management, where there is a termination between the medical group and their specialist, ancillary, or hospital where applicable, medical group will provide notification to the membership affected by the termination. The notification may identify an alternate provider and include an explanation of COC rights. The medical group can review and approve a COC request according to policy. However, if the medical group cannot approve, the request is redirected to Cigna for final determination. If Cigna receives a request through member services, Cigna will coordinate the review outcome with the applicable l delegated group.	

Colorado	• 60 days to submit request • At least 90 days if request approved	• Written notice of termination to covered persons shall include patients who have been seen by the provider being removed in the previous 12 months • Must provide COC for at least 90 days • Can be considered for COC and "in active treatment if seen by the provider in the past 12 months • Has 60 calendar days from termination of provider to submit COC request • The provider must agree in writing not to seek payment from the covered person for any amount which the covered person would not have been responsible if the provider was still participating.

District of Columbia	• At least 90 days (including 2nd trimester of pregnancy)	• Must provide COC for at least 90 days
Delaware *(HMO only – all other products follow Cigna standard)*	• Up to 120 days • Pregnancy through completion of postpartum care	• Must provide COC for up to 120 days
Florida	• **Through completion of treatment of a condition for which the customer was receiving care at time of termination, until customer selects new provider or during next open enrollment, not to exceed 6 months after provider contract termination.** • Pregnancy through postpartum care regardless of trimester	• May need to provide medically necessary COC for up to 6 months if customer does not select new provider within that time. • COC for pregnancy may begin during 1st trimester

Kentucky	• Up to 90 days • Up to 9 months for terminal illness • 2nd trimester of pregnancy through postpartum care within 6 weeks of delivery • Discharge from inpatient hospital • Active course of treatment completed	• Must provide COC for terminal illness for up to 9 months
Louisiana	• High-risk pregnancy or pregnancy in 24th week through delivery and postpartum care • Life-threatening illness up to 3 months	• Must provide COC for high-risk pregnancy (trimester not a factor)
Maine	• At least 60 days COC • 2nd trimester of pregnancy through postpartum care	• Must provide COC for *at least* 60 days
Maryland	• At least 90 days COC	• Must provide COC for *at least* 90 days
Massachusetts	• At least 30 days after primary care type physician termination • 2nd or 3rd trimester of pregnancy including first postpartum visit • Until participant's death if terminally ill	• COC for any reason when primary care type physician terminates; must be provided for *at least* 30 days • COC for terminal illness until customer's death – no time limit
Michigan	• 90 days • 2nd or 3rd trimester of pregnancy through postpartum care • Until participant's death if terminally ill	• COC for terminal illness until customer's death – no time limit

Minnesota	• Up to 120 days (including pregnancy beyond 1st trimester) If a physician, advance practice registered nurse, or physician assistant certifies that a member has a life expectancy of 180 days or less, uninterrupted coverage must be provided for the remainder of the member's life. • Allows same COC 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 up to 120 days of COC • COC for pregnancy may begin during 1st trimester • COC for terminal illness for up to 180 days (if life expectancy is 180 days or less) • COC for customers receiving culturally appropriate services or who do not speak English (provided there is no comparable provider in-network)
Nevada	• Up to the 120th day after the date the contact is terminated • Pregnancy – the 45th day after the date of delivery; or if the pregnancy does not end in delivery, the date of the end of the pregnancy	• Must allow up to 120 days of COC • COC for pregnancy continues through the 45th day after the delivery or if the pregnancy does not end in delivery, than the date of the end of the pregnancy
New Hampshire	• Not to be less than 60 days COC • We cannot require that customer complete the form- they are allowed this COC period without contingencies • We must include all providers including ancillary	• We will follow the 90 day Cigna standard • We must cover all COC claims for 90 days • Cannot deny ancillary COC

New Jersey	• Up to 4 months • Pregnancy up to 6 weeks after delivery • Up to 6 months for post-op care • Up to 1 year for oncology treatment • Up to 1 year for psychiatric treatment	• Must allow COC for up to 4 months • COC for post-op care up to 6 months • COC for oncology treatment up to 1 year • COC for psychiatric treatment up to 1 year
New Mexico	• Not to be less than 30 days COC • 3rd trimester of pregnancy shall include postpartum care	• Must provide COC coverage for *at least* 30 days
New York	• Up to 90 days **BUT** the 90-day coverage period begins on the date customer receives notice of provider termination, and written notice must be provided to customer within 15 (calendar) days of the date the carrier is aware of termination (including primary care type physician, specialist, hospital) and must disclose COC rights. • 2nd trimester of pregnancy through postpartum	• Standard meets requirements of the law provided that the 90-day clock does not start on the provider's actual termination date but on the date the customer receives notification of provider termination; **AND** • Appeals must be handled under the terms of the NY Administrative Appeal P&P for fully insured customers
North Carolina	• Up to 90 days (including pregnancy from 2nd trimester) • Until customer's death if terminally ill	• COC for terminal illness until customer's death – no time limit
Oregon	• Up to 120 days • 2nd trimester of pregnancy through 45 days after birth • Completion of active course of treatment	• Must provide COC for up to 120 days

Rhode Island	• Completion of active course of treatment • Not more than 1 year COC	• May be required to provide COC for up to 1 year (if acute course of treatment not complete by that time) *Law applies to provider contracts*
Tennessee	• 120 days • 2nd trimester of pregnancy through completion of postpartum care • Inpatient discharge COC period begins upon notice of provider termination, which is sent 60 days prior to actual termination date. Standard processes allow COC for 90 days from actual date of termination, so Cigna standard exceeds state law.	• Tennessee
Texas	• Up to 90 days • Up to 9 months for terminal illness • 24th week of pregnancy through 6 weeks after delivery	• COC must be provided for terminal illness up to 9 months • Appeals must be handled under the terms of the TX Administrative Complaint & Appeals P&P for fully insured customers **Law applies to HMO provider contracts**

Virginia	• 90 days for an "active course of treatment" (a primary care type physician may not need to demonstrate a "course of treatment") • 2nd trimester of pregnancy through postpartum care • Terminally ill for remainder of customer's life	• Must provide COC for terminal illness until customer's death – no time limit
Washington	• For primary care type physicians, at least 60 days or for plans with open enrollment periods, until the end of the next open enrollment period.	• For terminating primary care type physicians, at least 60 days or for plans with open enrollment periods for selection of new primary care type physicians, until the end of the next open enrollment period. • For all other providers, follow Cigna standard.
West Virginia	• At least 60 days	• Must provide COC for *at least* 60 days
Wisconsin	• Remainder of course of treatment, not more than 90 days • 2nd or 3rd trimester of pregnancy through postpartum care • PCP: end of current plan year or end of plan year for which primary care type physician was participating	• Must provide COC until end of current plan year if customer's primary care type physician terminates

STATES WITH CONTINUITY OF CARE LAWS THAT DO NOT DEVIATE FROM CIGNA STANDARD PROCESS

ATTACHMENT 2:

STATE	CONTINUITY OF CARE REQUIREMENTS
Cigna Standard	COC period = 90 days from provider termination date Customer/provider must submit request within 45 calendar days of provider termination date. • Terminal conditions • Acute conditions in active treatment or chronic condition requiring close medical management and frequent visits • 2nd or 3rd trimesters of pregnancy through the postpartum period (6 weeks after delivery). Facilities will be covered for maternity Cases if the provider is authorized and does not have privileges at a participating facility.
Arizona	• 30 days for life threatening disease of condition • 3rd trimester of pregnancy, up to 6 weeks after delivery
Arkansas	For current acute condition may receive treatment: • Until treatment ends OR • Up to 90 days
Georgia	• Up to 60 days for chronic illness • Up to 60 days for inpatient hospital stay • Pregnancy through 6 weeks of postpartum care *Law applies to provider contracts*

STATES WITH CONTINUITY OF CARE LAWS THAT DO NOT DEVIATE FROM CIGNA STANDARD PROCESS

ATTACHMENT 2:

Illinois	• 90 days • 3rd trimester of pregnancy through postpartum
Indiana	• 60 days • 3rd trimester of pregnancy throughout term of pregnancy • For hospitals, until earlier of 60 days following provider termination or patient released from hospital. *Law applies to HMO provider contracts*
Iowa	• Terminal illness or related condition for up to 90 days • 2nd or 3rd trimester of pregnancy through postpartum care
Kansas *(law is HMO only)*	• Up to 90 days • 3rd trimester of pregnancy
Mississippi	• Requires COC provisions in the case of an HMO's/insurer's insolvency
Missouri *(law is HMO only)*	• Up to 90 days if medically necessary, including disability, pregnancy or life threatening illness. *Law applies to provider contracts*
Montana	• Timeframe and conditions not specified; managed care plan must only contain plan for continuity of care in the event of contract termination.

STATES WITH CONTINUITY OF CARE LAWS THAT DO NOT DEVIATE FROM CIGNA STANDARD PROCESS

ATTACHMENT 2:

New Hampshire	• Renewal date of enrollee's plan; **OR** • 60 days after expiration date of provider contract, whichever is sooner *Law applies to provider contracts*
Oklahoma	• Up to 90 days (including terminal illness) • 3rd trimester of pregnancy through 6 weeks of postpartum
Pennsylvania	• Up to 60 days • 2nd or 3rd trimester of pregnancy through postpartum
South Dakota	• 90 days • 2nd trimester of pregnancy through postpartum
Vermont	• 60 days or until accepted by new provider, whichever shorter • 2nd or 3rd trimester of pregnancy until completion of postpartum

States without COC laws:
Alabama, Connecticut, Hawaii, Idaho, Mississippi, Montana, Nebraska, Nevada, North Dakota, Ohio, Puerto Rico, South Carolina, Utah, Virgin Islands, Wyoming