BLUE CROSS AND BLUE SHIELD OF ILLINOIS
PROCEDURE

DEPARTMENT: Network Provider Performance	**POLICY NUMBER: Medical Support 01A**	**ORIGINAL EFFECTIVE DATE: 7/1/2000**
POLICY TITLE: Continuity of Care		**EFFECTIVE DATE:04/01/2023**
		LAST REVISION DATE: 4/1/2023
EXECUTIVE OWNER: DSVP, IL Health Care Delivery	**BUSINESS OWNER: Executive Director, Network Performance**	**LAST REVIEW DATE: 04/01/2023**

I. SCOPE

This Procedure applies to the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
HMO Commercial	x
HMO Exchange	x
Health Care Delivery QI HMO Commercial	
Health Care Delivery QI PPO Commercial	
Health Care Delivery QI HMO Exchange	
Health Care Delivery QI PPO Exchange	

II. PROCEDURE

Definition:

Continuity of Care (CoC) Duration: HMO members can choose to continue services with the same in-network coverage for either (the earlier date):

- Up to 90 days-post member notice of provider termination, or
- The date they are no longer a continuing care patient

Continuity of Care is applicable under the following circumstances when a member:

- Is displaced due to a specific Primary Care Physician (PCP), Participating Specialist Provider (PSP) or IPA, termination, or
- Is new to the HMO with an existing condition that is being treated by an out of network provider.

1. The HMO and/or IPA notifies new and existing members of the availability of CoC services through the following methods:
    - Member certificate booklet
    - Enrollment materials

- Physician departicipation letters

2. ***CoC*** services are coordinated for new and existing members identified as currently undergoing a course of evaluation and/or medical treatment.
   Coverage will be provided only for benefits outlined in the member's certificate.

   Examples of medical treatment may include, but are not limited to the following:
   - 1st trimester obstetrics up to 90 days post-notice of provider termination
   - 2nd and 3rd trimester obstetrics including a six-week postpartum period starting immediately after childbirth.
   - High risk obstetrics (as diagnosed during pregnancy)
   - Chemotherapy and other cancer treatments
   - Determined to be terminally ill
   - Physical/Occupational/Speech therapies
   - Allergy treatments
   - Behavioral Health Services
   - Scheduled to undergo elective surgery including post-operative care
   - Chronic illness or acute medical conditions (e.g., diabetes, hypertension) which requires frequent monitoring by a physician
   - Home Health *C*are
   - Current hospitalizations
   - Skilled Nursing *C*are
   - Infertility treatment

3. The following timeframes apply:
   a) New members must request transitional services in writing, within 15 calendar days after their HMO eligibility effective date.

   b) Existing HMO members must request transitional services in writing, within 30 calendar days after receiving notification of the termination of the physician or IPA.

4. Services can only be requested if the physician is not contracted with any IPA within the HMO network and the physician still remains within the health care plan's service area.
   Note: If the provider is in the HMO network, the member has access via selection of the appropriate IPA that contracts with the provider and therefore transitional services are not applicable.

5. Upon receipt of a CoC request, the Customer Assistance Unit (CAU) calls the member to complete the CoC form and/or sends the member a CoC form for completion of the following information:

   - Member name
   - Work/home phone number
   - Group/ID number
   - Chosen IPA site
   - Chosen PCP name, phone, fax and address
   - Current treating physician

- Clinical diagnosis
- Presenting clinical condition
- Reason for transition of care request
- Expected effective date with the HMO or new IPA (if applicable)

For new members, the member's selected IPA, if known, is sent a copy of the member's CoC confirmation letter**.** The member's new IPA is responsible for managing all non-CoC related care and the standard financial responsibility applies for all non-CoC related care.

III. CONTROLS/MONITORING

Line of Business and/or Area	Control Requirements
HMO	Controls are detailed in the Policy itself

IV. AUTHORITY AND RESPONSIBILITY

[Identify the person(s) responsible for planning, coordinating and implementing the Procedure.]

V. SOURCE/REFERENCES

Federal/State	Regulatory Requirements & References
Federal	H.R.2471 - Consolidated Appropriations Act, 2022

VI. IMPACTED BUSINESS AREAS

HMO CAU and HMO Network Provider Performance are responsible for maintaining and adhering to Continuity of Care guidelines for HMO members.

VII. IMPACTED EXTERNAL ENTITIES

HMO Customer Assistant Unit
HMO Clinical Programs Strategy and Oversight
HMO Network Operations/Provider Performance
HMO Service Centers

VIII. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
Ernestine Brown	HMO CAU Manager	March 2, 2022
Mary Ellen Merbeth RN. BSN	HMO Provider Network Consultant	March 2, 2022
Danielle Washington	HMO PNC	August 3, 2022

IX. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Updated TOC Form	8/3/2022
Replaced TOC with COC	3/15/2023

X. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
BCBSIL P&P			3/24/2022
BCBSIL P&P			8/25/2022
BCBSIL P&P			3/23/2023

XI. PROCEDURE ATTACHMENTS / ADDITIONAL INFORMATION

Date

Name
Address
City, State Zip Code

Re: Patient Name:
Group And Id Number:
Transition Of Care Services For:

Dear Member Last Name:

Please accept this letter as formal notification that your continuity of care request cannot be processed by Blue Cross and Blue Shield of Illinois because it was not received within the 30-calendar day timeframe allowed for an existing member.

As a reminder, any services provided by Provider Name on or after date are considered out-of-network and are not eligible for payment. Please contact your selected Medical Group to arrange for your care and/or treatment.

If you should have any questions, you can contact us by either calling the Customer Service phone number on the back of your ID card or writing to Blue Cross and Blue Shield of Illinois at :

Blue Cross and Blue Shield of Illinois
Health Care Management
Customer Assistance Unit
1000 Warrenville Road, Suite 120,
Naperville, Illinois, 60563.

Sincerely,

_____
Health Services Assistant

Date

Name
Address
City, State. Zip

Re: Name
Group/Sub #
Transition of Care Services for: Anxiety & Depression

Dear*:*

Please accept this letter as formal notification that your transition of care request cannot be processed by Blue Cross and Blue Shield of HMO Illinois because **you do not qualify. To qualify for a continuity of care, you would have to be a new member of HMO, displaced due to a specific Primary Care Physician or Medical Group Termination and currently undergoing a course of evaluation and/or treatment.**

As a reminder, any services provided by Provider Name are considered out-of-network and are not eligible for payment. Please contact your current Primary care Physician to arrange for continuation of this care and/or treatment.

If you should have any questions, you can contact us by either calling the Customer Service phone number on the back of your ID card or writing to Blue Cross and Blue Shield of Illinois at

Blue Cross and Blue Shield of Illinois
Health Care Management
Customer Assistance Unit
1000 Warrenville Road, Suite 120,
Naperville, Illinois, 60563.

Sincerely,

_____
Health Services Assistant
Health Care Management

Date

Name
Address
City, State Zip

Re:
Group/ID#:
Case #:

Dear :

Please allow this letter to serve as a response to your request for continuity of care. You will be allowed to continue to see Provider Name from Month DD, YYYY to Month DD, YYYY.

Our letter can serve as the referral for these services. Also, you will be required to pay any co-payments or deductibles, if applicable, for any of the continuity of care services. Additional follow-up care after the above-mentioned date needs to be coordinated with your new Primary Care Physician and Medical Group. No additional bills from Provider Name will be paid after the above date.

If you receive any claims for these services, please send them with a copy of this letter to:

Blue Cross and Blue Shield of Illinois
Customer Assistance Unit
1000 Warrenville Road, 1st Floor
Naperville, Illinois 60563

If applicable, please remember from Month DD, YYYY you may need to select a new Medical Group and Primary Care Physician for your other health care needs. Please provide a copy of this letter to your selected Medical Group for their records if they have not been copied. This will help them to coordinate your care after the transition period ends.

If you should have any questions, please call me at (312) 653-6600.

Sincerely,

Health Services Assistant
Health Care Management

cc: IPA Name

Date

Name
Address
City, State. Zip

Re: Member Name
Group/Subscriber
Continuity of Care Services for: 3rd Trimester Pregnancy

Dear **:**

Please allow this letter to serve as a response to your request for continuity of care. You will be allowed to continue to see Provider Name from MM/DD/YYYY through delivery and one post-partum care checkup.

Our letter can serve as the referral for these services. Also, you will be required to pay any co-payments or deductibles, if applicable, for any of the continuity of care services. Additional follow-up care after the above-mentioned date needs to be coordinated with your new Primary Care Physician and Medical Group. No additional bills from Rush Associates & Women's Health will be paid after the above date.

If you receive any claims for these services, please send them with a copy of this letter to:

Blue Cross and Blue Shield of Illinois
Health Care Management
Customer Assistance Unit
1000 Warrenville Road, Suite 120
Naperville, Illinois 60563

If applicable, please remember from MM/DD/YYYY, you may need to select a new Medical Group and Primary Care Physician for your other health care needs. Please provide a copy of this letter to your selected Medical Group for their records if they have not been copied. This will help them to coordinate your care after the transition period ends.

If you should have any questions, please call me at (312) 653-6600.

Sincerely,

Health Services Assistant

Health Care Management

Cc: IPA Name

URGENT CONFIDENTIAL FAX – PROTECTED HEALTH INFORMATION

Attention:	«Physician_First_Name» «Physician_Last_Name»		
Address:	«Provider_Address» «Provider_City», «Provider_State» «Provider_Zip»		
Phone & Fax:	Phone: «Provider_Phone»	Fax: «Provider_FAX»	
From:	«HS_A_name»	Phone: (312) 653-6600	
Date	April 26, 2023		
Group #: «Group_»	Sub #: «Subscriber_ID»	Case #: «Case_»	
Patient Name:	«Patient_First_Name» «Patient_Last_Name»		
Diagnosis	«Clinical_Diagnosis»		

Dear Provider:

Blue Cross Blue Shield of Illinois (BCBSIL) is in receipt of a request from the above member to continue care with you from «Provider_Termination_date» to «COC_End_Date». The ***Continuity*** of Care (**C**OC) process allows an HMO member to continue seeing his/her existing provider for on acute or chronic medical condition when it is medically appropriate. A **C**OC request may come to you when a member joins HMO from a different insurer, when a member's provider leaves the HMO network or when the member has switched HMO medical groups and you are not contracted with the new medical group. Please be advised that no request will be approved beyond a ninety (90) day period except for second and third trimester pregnancies which will be approved through the postpartum visit

Claims for services provided from «Provider_Termination_date» through «COC_End_Date» will be adjudicated using the «SChedule_Year» «Schedule_Type» fee schedule. Applicable co-payments and/or deductibles will apply to all transition of care services.

WHAT YOU NEED TO DO
Please complete the treatment plan and email or fax the document within the next five (5) business days («Expected_Return_Date») to my attention. You are welcome to call me with questions at (312) 653-6600.

Email: HMOCAUUnit@bcbsil.com
Fax #: (312) 729-7267

Services not related to the diagnosis on the treatment plan must be coordinated through the member's new primary care physician. As of «**CoC**_End_Date» all services must be coordinated through the member's medical group or IPA.

All claims for transition of care services should be sent to:

Blue Cross and Blue Shield of IL
HMO Member Services
2787 McFarland Rd, Rockford, IL 61107-6815

Thank you for your assistance with this member.

«HS_A_name»
Customer Assistant Unit

CONTINUITY OF CARE TREATMENT PLAN

Group #: «Group_»	Subscriber #: «Subscriber_ID»	Case #:
Provider Name:	«Physician_First_Name» «Physician_Last_Name»	
Diagnosis/Presenting Clinical Condition	«Clinical_Diagnosis»	

Brief Outline of Scheduled Treatment Plan:

Please email or fax the treatment plan by five (5) business days «Expected_Return_Date» to:
«HS_A_name»
(312) 729-7267
Thank you

URGENT CONFIDENTIAL FAX – PROTECTED HEALTH INFORMATION

Attention:	«Physician_First_Name» «Physician_Last_Name»		
Address:	«Provider_Address» «Provider_City», «Provider_State» «Provider_Zip»		
Phone & Fax:	Phone: «Provider_Phone»	Fax: «Provider_FAX»	
From:	«HS_A_name»	Phone: (312) 653-6600	
Date	April 26, 2023		
Group #: «Group_»	Sub #: «Subscriber_ID»	Case #: «Case_»	
Patient Name:	«Patient_First_Name» «Patient_Last_Name»		

Dear Provider:

Blue Cross Blue Shield of Illinois (BCBSIL) is in receipt of a request from the above member to continue care with you from «Provider_Termination_date» to the postpartum visit. The **Continuity** of Care (COC) process allows an HMO member to continue seeing his/her existing provider for on acute or chronic medical condition when it is medically appropriate. A TOC request may come to you when a member joins HMO from a different insurer, when a member's provider leaves the HMO network or when the member has switched HMO medical groups and you are not contracted with the new medical group. Please be advised that no request will be approved beyond a ninety (90) day period except for second and third trimester pregnancies which will be approved through the postpartum visit.

Claims for services provided from «Provider_Termination_date» through the postpartum visit will be adjudicated will be adjudicated using the «SChedule_Year» «Schedule_Type» fee schedule. Applicable co-payments and/or deductibles will apply to all transition of care services.

WHAT YOU NEED TO DO
Please complete the treatment plan and email or fax the document within the next five (5) business days («Expected_Return_Date») to my attention. You are welcome to call me with questions at (312) 653-6600.

Email: HMOCAUUnit@bcbsil.com
Fax #: (312) 729-7267

Services not related to the diagnosis on the treatment plan must be coordinated through the member's new primary care physician. Any services after the postpartum visit must be coordinated through the member's medical group or IPA.

All claims for **continuity** of care services should be sent to:

Blue Cross and Blue Shield of IL
HMO Member Services
2787 McFarland Rd, Rockford, IL 61107-6815

Thank you for your assistance with this member.

«HS_A_name»
Customer Assistant Unit

CONTINUITY OF CARE TREATMENT PLAN

Group #: «Group_»	Subscriber #: «Subscriber_ID»	Case #: «Case_»
Provider Name:	«Physician_First_Name» «Physician_Last_Name»	
Diagnosis/Presenting Clinical Condition	«Clinical_Diagnosis»	

Brief Outline of Scheduled Treatment Plan:

Please email or fax the treatment plan by five (5) business days «Expected_Return_Date» to:
«HS_A_name»
(312) 729-7267

Thank you

- STOP -

YOU MUST BE ENROLLED BEFORE COMPLETING THIS FORM

HMO Continuity of Care Form

Patient First Name:	Patient Last Name:
Group/ ID Number:	**Date of Birth:**
Home phone number	**Work phone number:**

PHYSICIAN REQUESTED FOR THE TRANSITION PERIOD

First Name:	**Last Name:**
Address:	
Phone Number:	**Fax Number:**
Clinical Diagnosis:	
Presenting Clinical Condition:	
Reason for Continuity of Care Request:	

If you are a new member what is your effective date with the HMO?	
Chosen PCP:	**Chosen WPHCP:**
Chosen MG/IPA:	**Chosen WPHCP MG/IPA:**

Attention: Existing HMO Members

Continuity of Care form must be received by Blue Cross Blue Shield within 30 calendar days after receiving notification of the termination of your physician or medical group/IPA.

Attention New Members

Continuity of Care form must be received by Blue Cross Blue Shield within 15 calendar days after your eligibility effective date. If you are submitting this form prior to your effective date, please include copy of signed application and/or confirmation of enrollment with the HMO.

Continuity of Care Form may be faxed to the Customer Assistance Unit at 312-729-7267 or mailed to:

Blue Cross Blue Shield of Illinois
Attention: CAU Department
300 E. Randolph, 24th Floor
Chicago, Illinois 60601