BLUE CROSS AND BLUE SHIELD OF ILLINOIS
MEDICARE ADVANTAGE HMO

DEPARTMENT: IL Provider Performance Management	**PROCEDURE NUMBER:** GCS-IL-MA-22B	**ORIGINAL EFFECTIVE DATE (IF KNOWN):** 01/01/2013
PROCEDURE TITLE: Transition of Medical Care Procedure		**EFFECTIVE DATE:** 08/09/2022
		LAST REVISION DATE: 08/09/2022
EXECUTIVE OWNER: Executive Director, Provider Performance	**BUSINESS OWNER:** Manager, Provider Performance	**LAST REVIEW DATE:** 08/09/2022

I. SCOPE

This Procedure applies to Provider Performance Management government product Medicare Advantage HMO.

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]
Medicare MAPD/H3822/H8547/H0927	X
Note: Future fully executed contracts will fall under this procedure.	

II. POLICIES IMPLEMENTED BY PROCEDURE

This Procedure implements the following Policies:

Transition of Medical Care Policy, GCS-IL-MA-22A. This procedures document ensures there is a documented process for Transition of Medical Care.

III. PROCEDURE

1. The MA HMO and/or IPA/ contracted provider informs existing members of the availability of Transition of Care (TOC) services through the following resources:
- Member certificate
- Enrollment materials
- Physician deparcipation letters

2. TOC services are coordinated for new and existing members identified as currently undergoing a course of evaluation and/or medical treatment or have entered into the second or third trimester of pregnancy. Coverage is provided only for benefits outlined in the member's EOC.

a. Examples of medical treatment may include, but are not limited to, the following:
- 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
- Physical/Occupational/Speech therapies
- Allergy treatments
- Behavioral Health Services
- Scheduled invasive procedures (e.g., angioplasty, surgery)
- Chronic illness or acute medical conditions (e.g., diabetes, hypertension) which requires frequent monitoring by a physician
- Home health care
- Current hospitalizations
- Skilled nursing care (SNF)

3. Members must request the option of transitional services in writing within the following timeframes:
- New members must request transitional services within fifteen (15) calendar days after their eligibility effective date.
- Existing members must request transitional services within thirty (30) calendar days after receiving notification of the termination of the physician or IPA to the Medical Group or to MA HMO.

4. Services can only be requested if the physician is not contracted with the applicable MA HMO network, but is within the health care plan's service area.

5. Upon receipt of a TOC request, the IPA or MA HMO sends the member a TOC form (*see Sample 1*) 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 the TOC request
- Expected effective date with the MA HMO or new IPA (if applicable)

6. Upon receipt of information from the member, the IPA or MA HMO responds to the member (*see Sample 2*), if applicable, with the approval.

7. The provider must return the signed letter within five (5) business days from receipt (*see Sample 3*). The letter will include:

- Reimbursement from the MA HMO at specified rates
- Adherence to the MA HMO's Quality Assurance Requirements and the MA HMO's policies and procedures

If the provider submits a signed letter and treatment plan, the IPA or MA HMO will send the member a confirmation of treatment authorization with applicable guidelines within fifteen (15) business days of receipt of the original request.

For existing members, the member's selected IPA or MA HMO is sent a copy of the member's TOC
confirmation letter. The member's IPA or MA HMO is responsible for managing all nonTOC related services and the standard financial responsibility applies for all nonTOC related services.

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

8.

SAMPLE 1 – SAMPLE TRANSITION OF CARE ACKNOWLEDGEMENT AND REQUEST FOR INFORMATION (EXISTING MEMBER)

DATE: _____

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re: Patient Name Group and Member ID # Transition of Care request

Dear _____:

The (insert IPA or MA HMO name) is in receipt of your letter requesting transition of care services. We cannot process your request without additional information.

Please submit the following:

- Your home or mobile telephone number
- Name, address, phone and fax number of the physician you wish to continue to see
- The condition for which you are currently seeing the physician
- The type and frequency of services you expect to need during the transitional period

Once we receive this information, we will process your request. Please keep in mind this information must be submitted within 30 days of the receipt of the original letter notifying you that your current Independent Physicians Association (IPA) or physician will no longer be in our network.
Your letter should be directed to the attention of:

Blue Cross Medicare Advantage c/o provider P.O. BOX 3686 Scranton, PA. 18505

SAMPLE 2 – APPROVED TRANSITION OF CARE (MEMBER)
(this letter would be sent to the member once the agreement and treatment plan is received)

DATE

SUBSCRIBER AND/OR PATIENT NAME ADDRESS CITY/STATE

Re: **PATIENT NAME CASE #**_____ **GROUP AND MEMBER ID**

Dear **PATIENT NAME:**

Please allow this letter to serve as a response to your request for transitional care. You will be allowed to continue to see **DOCTOR NAME** from ____ to_____ ***for*** (**REASON/DX)**.

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 transition of care services.** Additional follow-up care after the above-mentioned date needs to be coordinated with your new

Primary Care Physician (PCP) and Independent Physician Association (IPA) (if applicable). **No additional bills from DOCTOR 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 Medicare Advantage c/o provider services
P.O. BOX 3686 Scranton, PA. 18505

If applicable, please remember as of DATE, you will need to select a new Primary Care Physician and Medical Group (if applicable) for all your healthcare services (

If you should have any questions, please call me at xxx-xxx-xxxx.

Sincerely,

_____

SAMPLE 3 – TRANSITION OF CARE LETTER OF AGREEMENT (DOCTOR)

«DateofLetter» «PhysicianName» «PhysicianAddress» «PhysCityStateZip» Re: «PatientName» «PatientGroupID» Dear «PhysicianName»:

We are in receipt of a letter from the above member for continuation of care after «TOCDate» . Consider this letter as a contractual agreement between «PhysicianName» and Blue Cross and Blue Shield of Illinois, that you are agreeing to coordinate transitional care for this member. Please sign below and provide us with a copy of the patient's diagnosis and current treatment plan within the next five business days. Please be advised that no treatment plan will be approved beyond a 90-calendar day period except for 2nd and 3rd trimester pregnancies which will be approved through the six-week postpartum period that starts immediately after childbirth. If we do not hear from you within this five-day period, we will notify the patient that their request has been denied.

The claims for services provided after «TOCDate» will be adjudicated using the current year Medicare Resource Based Relative Value Scale Locality 16 fee schedule. Applicable copayments and/or deductibles will apply to all transition of care services. Signing this letter of agreement indicates you are accepting the Medicare reimbursement as payment in full and you will not balance bill the patient. You are also agreeing to provide, **upon request,** any applicable medical records pertaining to this patient. Please sign below, date and fax a copy of this letter and the treatment plan to my attention at (312) *XXX-XXXX*.

MD Signature: _____

_____

Date:

Effective «TOCDate» the member must coordinate all other services not included in the treatment plan with their new IPA (if applicable) and Primary Care Physician. Any services that are not related to this diagnosis and treatment plan will not be paid. If this member requires additional services**,** the member should be referred to their primary care physician.

If it becomes necessary to further refer this member for additional services related to the diagnosis on the treatment plan, please contact me for authorization at 312-xxx-xxxx. Referred services that are related to the diagnosis on the treatment plan will not be approved without prior authorization.

All claims for services should be sent with a copy of this letter to:

Blue Cross and Blue Shield of Illinois
P.O. BOX 3686 Scranton, PA. 18505
Thank you very much for your cooperation with this patient. If you have any questions, please feel free to call me at (312) xxx-xxxx, fax number (312) xxx-xxxx.

Sincerely,

Network Development Person's Name
Network Development Person's Title, Network Development

IV. CONTROLS/MONITORING

Control Document or Control Description	Control Owner
UM Review of Sample Letters Annually	Manager, Illinois Provider Performance Management

V. AUTHORITY AND RESPONSIBILITY

- Lupita Monroy, (Manager, Illinois Provider Performance Management)

VI. SOURCES/REFERENCES

Federal/State	Regulatory Requirements & References
2021 Illinois MMAI Demonstration Contract	2.5.4 Transition of Care 2.5.4.1 Transition of Care Process. The Contractor will manage transition of care and continuity of care for new Enrollees, Enrollees moving from hospital back to Enrollee's home or NF. The Contractor's process for facilitating continuity of care will include: 2.5.4.1.1 Identification of Enrollees needing transition of care. 2.5.4.1.2 Communication with entities involves in Enrollees' transition 2.5.4.1.3 Making accommodations so that all community supports, including housing, are in pace prior to the Enrollee's move and that Providers are fully knowledgeable and prepared to support the Enrollee, including interface and coordination with and among social supports, clinical services and LTSS 2.5.4.1.4 Environmental adaptions and equipment and technology the Enrollee needs for a successful care setting transition 2.5.4.1.5 Stabilization and provision of uninterrupted access to covered services for the Enrollee 2.5.4.1.6 Assessment of Enrollees' ongoing care needs. 2.5.4.1.7 Monitoring of continuity and quality of care, and services provided 2.5.4.1.8 Medication reconciliation 2.5.4.2 Transition of Care Plan. 2.5.4.3 Transition of Care Team. 2.5.4.4 Transition of Enrollees 2.5.4.4.1 2.5.4.4.2 2.5.4.4.3 2.5.4.4.5 2.5.4.4.6 2.5.4.5 2.5.4.5 2.5.4.7

VII. PROCEDURE REVIEWERS

Person Responsible for Review, Committee Reviewing as FYI	Title	Date of Review
Lupita Monroy	Manager, Illinois Provider Performance Management	06/07/2022
Sandra Hopson	Provider Affairs Project Consultant, Illinois Provider Performance Management	06/05/2022

VIII. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Annual Review	07/12/2022
New Template	05/14/2021

IX. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Medicare P&P Com m			08/09/2022
IL Provider Performance Management	Joanne brien O'	Executive Director	06/10/2022
IL Provider Performance Management	Joanne 'brien O	Executive Director	06/18/2021