**Policy Name:** Transition of Medical Care  
**Policy Number:** Medical Support – 01  
**Effective Date:** 7/1/00  
**Revision Date:** 04/01/2019  
**Review Date:** 04/01/2019  

**Approval Signature**  
4/18/2019

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**Divisional Senior Vice President IL Health Care Delivery**

**Line of Business**

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<th>Commercial</th>
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**Approving Body**

- ☑ Policy and Procedure Committee  
  Date: 03/28/19

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**Details**

**POLICY:**

Blue Cross and Blue Shield of Illinois (BCBSIL) provides that Transition of Care (TOC) may be available to new and existing members that are currently undergoing a course of evaluation and/or medical treatment.

**PURPOSE/OBJECTIVES:**

- To minimize disruptions of care and potential adverse clinical outcomes  
- To meet appropriate care expectations for both the member and the selected Medical Group/Individual Practice Association or Physician Hospital Organization (hereinafter the “IPAs”),

**GUIDELINES:**

TOC 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.

PROCEDURE:

1. The HMO and/or IPA notifies new and existing members of the availability of transitional care services through the following methods:
   - Member Policy book
   - Member certificate
   - Enrollment materials
   - Physician de-participation letters

2. TOC 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:
   - 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
   - Infertility treatment

3. The following timeframes apply:
   a) New members must request transitional services in writing, within 15 calendar days after their eligibility effective date.
   b) Existing 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 TOC request, the Customer Assistance Unit (CAU) calls the member to complete the TOC form and/or sends the member a TOC 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)

6. Once the TOC form is completed, the CAU sends a letter to the provider requesting the following:

- The clinical treatment plan
- Agreement to the HMO reimbursement rate(s)

7. The provider must return the signed letter within five business days from receipt.

8. If the provider indicates there is no current treatment plan, does not accept the terms of the agreement or does not respond within the five-business day timeframe, the TOC will be denied and the CAU will update the TOC database.

   a. The member is sent a denial letter within 15 calendar days of the original request and informed of the appeal rights.

9. If the provider submits a signed letter and treatment plan, the TOC will be approved and CAU will update the TOC database.

   a. The CAU will distribute the approval to the appropriate Service Centers. A notation is made in the member’s file indicating the HMO is financially responsible for TOC related services. A copy of the letter and treatment plan will be scanned into the original inquiry as an insert.

   b. The member is sent a confirmation of treatment authorization with applicable guidelines (clinical treatment approval, up to a maximum of 90 calendar days, etc.) within 15 calendar days of receipt of the original request.

For existing members, the member’s selected IPA is sent a copy of the member’s TOC confirmation letter. The member’s IPA is responsible for managing all non-TOC related care and the standard financial responsibility applies for all non-TOC related care.
For new members, the member’s selected IPA, if known, is sent a copy of the member’s TOC confirmation letter. The member’s new IPA is responsible for managing all non-TOC related care and the standard financial responsibility applies for all non-TOC related care.
SAMPLE 1 – 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 ____________________:

Blue Cross and Blue Shield of Illinois are in receipt of your letter requesting transition of care services. We cannot process your request without additional information. Please complete the attached Transition of Care form within 15 calendar days upon receipt of this notice.

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

Your letter should be directed to the attention of:

Blue Cross and Blue Shield of Illinois
Health Care Management
Customer Assistance Unit
1100 Warrenville Rd. 4th FL
Naperville, IL 60563

Please contact the Customer Service number listed on the back of your identification card if you require assistance selecting a new IPA

Sincerely,

____________________
Health Services Assistant
Health Care Management

Revised: 4/1/19
SAMPLE 1A - TRANSITION OF CARE ACKNOWLEDGEMENT AND REQUEST FOR INFORMATION (NEW MEMBER)

DATE: ____________________

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

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

Dear ____________________:

Blue Cross and Blue Shield of Illinois are in receipt of your letter requesting transition of care services. We cannot process your request without additional information. Please complete the attached Transition of Care form within 15 calendar days upon receipt of this notice.

Once we receive this information, we will process your request. Your form should be directed to my attention at:

    Blue Cross and Blue Shield of Illinois
    Health Care Management
    Customer Assistance Unit
    1100 Warrenville Rd. 4th FL
    Naperville, IL 60563

    Please contact Customer Service number listed on the back of your identification card if you require assistance selecting a new Medical Group.

Sincerely,

____________________
Health Services Assistant
Health Care Management

Revised: 4/1/19
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 Medical Group. 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 and Blue Shield of Illinois
Health Care Management
Customer Assistance Unit
1100 Warrenville Rd. 4th FL
Naperville, IL 60563

If applicable, please remember as of DATE, you will need to select a new Medical Group and PCP for all of your other health care needs. (or use the following: Please remember as of DATE, you will need to use your selected Medical Group or PCP for these services.) 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 (if available)
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 co-payments 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 Medical Group 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 the new IPA.

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 805107
Chicago, IL 60680-4112

Thank you very much for your cooperation with this patient. If you have any questions, please feel free to call me at (312) xxx-xxx, fax number (312) xxx-xxx.

Sincerely,

Network Development Person’s Name
Network Development Person’s Title, Network Development

Revised: 4/1/19
SAMPLE 4- DENIAL OF TRANSITION OF CARE (MEMBER)
(This letter would be sent to the member if no agreement or plan of treatment is received within 5 business days)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re: PATIENT NAME
   GROUP AND ID NUMBER
   Transition of Care Services for: DX OR SERVICES

Dear PATIENT NAME:

Please accept this letter as formal notification that your transition of care request has been denied by Blue Cross and Blue Shield of Illinois.

A letter was sent to DOCTOR NAME on DATE, requesting that he/she sign our letter of agreement and provide us with the treatment plan, however no response was received. Therefore, since DOCTOR NAME is not in our network, we are unable to pursue this matter further. Please contact your selected Medical Group to arrange for any care and/or treatment you require.

As a reminder, any services provided by DOCTOR NAME after DATE (new Medical Group effective date) are considered out-of-network and are not eligible for payment.

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, Health Care Management, Customer Assistance Unit, 1100 Warrenville Rd. 4th FL, Naperville, Illinois 60563,

Sincerely,

____________________
Health Services Assistant
Health Care Management
SAMPLE 5- DENIAL OF TRANSITION OF CARE   (MEMBER)
(This letter would be sent to the member if member’s request was received after either the 15 or 30 calendar days allowed.)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re:   PATIENT NAME
       GROUP AND ID NUMBER
       Transition of Care Services for:   DX OR SERVICES

Dear PATIENT NAME:

Please accept this letter as formal notification that your transition of care request has been denied by Blue Cross and Blue Shield of Illinois because it was not received within the 15 OR 30 calendar day timeframe allowed for (A NEW MEMBER OR AN EXISTING MEMBER).

As a reminder, any services provided by DOCTOR NAME after DATE (new Medical Group effective 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, Health Care Management, Customer Assistance Unit, 1100 Warrenville Rd. 4th FL, Naperville, Illinois 60563,

Sincerely,

____________________
Health Services Assistant
Health Care Management
SAMPLE 6- DENIAL OF TRANSITION OF CARE (MEMBER)
(This letter would be sent to the member if member’s request was not for services that would qualify for transition services)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re:  PATIENT NAME
GROUP AND ID NUMBER
Transition of Care Services for:  _DX OR SERVICES____

Dear  PATIENT NAME:

Please accept this letter as formal notification that your transition of care request has been denied by Blue Cross and Blue Shield of Illinois because your diagnosis and/or treatment plan does not qualify you for transition of care services.

As a reminder, any services provided by  DOCTOR NAME after  DATE (new Medical Group effective date) are considered out-of-network and are not eligible for payment. Please contact your assigned Medical Group 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, Health Care Management, Customer Assistance Unit, 1100 Warrenville Rd. 4th FL, Naperville, Illinois 60563, .

Sincerely,

____________________
Health Services Assistant
Health Care Management
SAMPLE 7- DENIAL OF TRANSITION OF CARE  (PROSPECTIVE MEMBER)

(This letter would be sent to a prospective member requesting transition services or a member that has no confirmation of membership)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re: PATIENT NAME
Transition of Care Services for: DX OR SERVICES

Dear PATIENT NAME:

This letter is in response to your inquiry received in our office on Date received requesting transition of care services.

This is to advise you that since you have no verification of membership, we are unable to move forward with your request for transition of care. Once you have been assigned a group and identification number or have received confirmation of your enrollment with the HMO, you will need to provide our office with this information. At that time, we can process your request for transition of care.

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

Sincerely,

____________________
Health Services Assistant
Health Care Management
- STOP -
YOU MUST BE ENROLLED BEFORE COMPLETING THIS FORM
HMO TRANSITION OF CARE FORM

<table>
<thead>
<tr>
<th>Patient First Name:</th>
<th>Patient Last Name:</th>
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<table>
<thead>
<tr>
<th>Group/ ID Number:</th>
<th>Date of Birth:</th>
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<th>Home phone number</th>
<th>Work phone number:</th>
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**PHYSICIAN REQUESTED FOR THE TRANSITION PERIOD**

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<tr>
<th>First Name:</th>
<th>Last Name:</th>
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<table>
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<tr>
<th>Phone Number:</th>
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<th>Clinical Diagnosis:</th>
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<th>Presenting Clinical Condition:</th>
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<th>Reason for Transition of Care Request:</th>
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**If you are a new member what is your effective date with the HMO?**

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<th>Chosen PCP:</th>
<th>Chosen WPHCP:</th>
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<tr>
<th>Chosen MG/IPA:</th>
<th>Chosen WPHCP MG/IPA:</th>
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**Attention: Existing HMO Members**
Transition 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**
Transition 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.

Transition 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
1100 Warrenville Rd. 4th FL
Naperville, Illinois 60563