

Transition of Care

Continuity of Care

What do Transition of Care and Continuity of Care mean to you?

Transition of Care

Transition of Care allows new members and/or members whose plan has experienced a recent provider network change to continue to receive services for specified medical and behavioral conditions, with health care professionals that are not participating in the plan's designated provider network, until the safe transfer of care to a participating provider and/or facility can be arranged. The provider must agree to accept network rates for the defined period of time. Examples of qualifying medical conditions can be found below. You must apply for Transition of Care no later than 30 days after the date your coverage becomes effective or after the effective date of the network change using the request form below.

Continuity of Care

Continuity of Care allows members the option to apply to receive services at in-network coverage levels for specified medical and behavioral conditions, from their current health care provider if the provider is or is soon to be out-of-network. This arrangement will be allowed until the safe transfer of care to a participating provider and/or facility can be arranged. The provider must agree to accept network rates for the defined period of time. Examples of covered medical conditions can be found below. You must apply for Continuity of Care within 30 days of your health care provider's termination date (this is the date your provider is leaving the network) using the request form below.

How do they both work?

You are eligible for a Transition of Care/Continuity of Care only when you have a significant medical condition that requires you to continue care with a specific provider as determined in each individual situation.

If your request is approved for the medical condition(s) listed on your request form(s), you will receive the network level of coverage for treatment of the specific condition(s) by the health care professional for a defined time frame, as determined upon approval by Performance Health.

All other services or supplies must be provided by a network health care professional for you to receive in-network coverage levels. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the timeframe approved by Performance Health, you must follow your plan's out-of-network requirements.

Transition of Care/Continuity of Care applies only to the treatment of the medical condition(s) specified and the health care provider identified on the request form submitted. The availability of Transition of Care/Continuity of Care does not guarantee that a treatment is medically necessary. Depending on the actual request, a medical necessity determination and a notification or prior authorization may still be required in order for a service to be covered.

What are some of the conditions that do and don't qualify?

Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Pregnancy in the second or third trimester at the time of the plan effective date of coverage or of the health care provider termination.
- Pregnancy is considered high risk if mother's age is 35 years or older, or patient has/had:
 - Early delivery (three weeks) in previous pregnancy.
 - Gestational diabetes.
 - Pregnancy induced hypertension.
 - Multiple inpatient admissions during this pregnancy.
- Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
- Trauma.
- Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries still in the follow-up period, that is generally six to eight weeks.
- Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions.
- "Active treatment" is defined as a provider visit or hospital stay with documented changes in a therapeutic regimen. This is within 21 days prior to your plan effective date or your health care provider's termination date.
- Hospital confinement on the plan effective date (only for those plans that do not have extension of coverage provisions).

Examples of conditions that do not qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Routine exams, vaccinations and health assessments.
- Stable chronic conditions such as diabetes, arthritis, allergies, asthma, hypertension and glaucoma.
- Acute minor illnesses such as colds, sore throats and ear infections.
- Elective scheduled surgeries such as removal of lesions, bunionectomy, hernia repair and hysterectomy.

What time frame is allowed for transitioning to an in-network provider?

If Performance Health determines that transitioning to an in-network health care provider is inappropriate or unsafe for the conditions that qualify, services by the approved out-of-network health care provider will be authorized for a specified period of time (usually 90 days). Or services will be approved until care has been completed or transitioned to an in-network health care provider, whichever comes first.

How do you apply for Transition/Continuity of Care?

A separate request form must be submitted for each condition. Requests must be submitted in writing, using the Transition of Care/Continuity of Care request form. This form must be submitted at the time of enrollment, change in plan's designated provider network, or when your health care provider leaves the plan's designated provider network. Transition of Care/Continuity of Care request forms can be submitted via mail to the address listed on the request form, faxed to 440-249-7276, or emailed to customerservice@myperformancehlth.com. It cannot be submitted more than 30 days after the effective date of your plan, the plan change, or your health care provider's termination with the designated provider. After receiving your request, Performance Health will review and evaluate the information provided. Then, we will send you a letter informing you whether your request was approved or denied. A denial will include information about how to appeal the determination.

Transition of Care/Continuity of Care Request Form

Please check one:

- ☐ I am a new plan member (Transition of Care applicant)
- ☐ I am an existing plan member. My designated provider network recently changed
- ☐ I am an existing plan member whose provider recently terminated or is terminating with my designated provider network

Effective Date of Change (MM/DD/YYYY): _____

Patient Information				
Employee/Participant Name		ID Number		
Patient Name		Patient Date of Birth	Relationship	
Patient Address	City	State	Zip Code	
Patient Primary Number		Patient Email Address		
Medical Information				
1. Is this patient pregnant and in the second or third trimester of pregnancy? Due Date: _____		☐	Yes	☐ No
2. Is the patient pregnant and considered high risk?		☐	Yes	☐ No
3. Is the patient currently receiving treatment for an acute condition or trauma?		☐	Yes	☐ No
4. Is the patient scheduled for surgery or hospitalization after the effective date of change above?		☐	Yes	☐ No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care?		☐	Yes	☐ No
6. Is the patient receiving treatment as a result of a recent major surgery?		☐	Yes	☐ No
7. Is the patient receiving dialysis treatment?		☐	Yes	☐ No
8. Is the patient a candidate for a organ transplant?		☐	Yes	☐ No
9. If you did not answer "Yes" to any of the above questions, please name the condition for which you are requesting Transition/Continuity of Care:				
10. Date of Diagnosis			MM/DD/YYYY	
11. Treatment being received and expected duration:				
12. List any scheduled treatments and date(s) scheduled:				

Who is or will no longer be in-network? Please check one. If multiple answers apply, a separate form will be required for each.

- ☐ Provider
☐ Facility
☐ Other _____

Provider Information			
Provider/Facility Name			
Provider/Facility Address	City	State	Zip Code
Provider/Facility Phone Number		Provider/Facility Specialty	
If applicable, Hospital where Provider practices		Hospital Phone Number	
Hospital Address	City	State	Zip Code

Patient Authorization	
I hereby authorize the above provider and/or facility to give Performance Health any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand I am entitled to a copy of this authorization form.	
Patient Name (Please Print)	Date (MM/DD/YYYY)
Patient Signature, Parent, or Guardian	Date (MM/DD/YYYY)

Submit this request form to:

Performance Health: Transition of Care/Continuity of Care Department
Mail: P.O. Box 450978 Westlake, OH 44145
Email: customerservice@myperformancehlth.com
Fax: 440-249-7276