

<p>SUBJECT: CLINICAL POLICIES – PRIOR AUTHORIZATION and CONTINUITY OF CARE – MEDICAL & BEHAVIORAL HEALTH - MA</p> <p>POLICY NUMBER: HS-CP-MA C2</p> <p>EFFECTIVE DATE: DECEMBER 17, 2025</p> <p>SERVICE/PRODUCT LINE: MEDICARE – MEDICAL & BEHAVIORAL HEALTH</p>	<p>Product Line (check all that apply):</p> <p><input type="checkbox"/> All</p> <p><input type="checkbox"/> Group HMO</p> <p><input type="checkbox"/> Individual HMO</p> <p><input type="checkbox"/> PPO</p> <p><input type="checkbox"/> POS</p> <p><input checked="" type="checkbox"/> Medicare</p> <p><input type="checkbox"/> N/A</p>
--	--

These guidelines are used in conjunction with the independent judgment of a qualified licensed physician and do not constitute the practice of medicine or medical advice. This Clinical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This Clinical Policy is not intended to recommend treatment for members. Members should consult with their treating provider in connection with diagnosis and treatment decisions.

When coverage criteria are not fully established by Medicare including but not limited to National Coverage Decisions (NCD), Local Coverage Decisions (LCD), Medicare Manuals and National Coverage Articles, Sharp Health Plan develops Clinical Policies that serve as recommendations for medical necessity decisions. Sharp Health Plan utilizes evidence-based guidelines from nationally recognized professional organizations, peer reviewed medical and scientific literature and evidence-based consensus statements, which are all based on generally accepted standards of care.

I. BENEFIT STATEMENT: Any service reviewed and approved by this Sharp Health Plan Clinical Policy must be a covered benefit according to the member’s evidence of coverage (EOC). Since benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in this clinical policy, decisions are subject to all terms and conditions of the applicable benefit plan. Benefit determinations should be based in all cases on the member’s contract benefits in effect at the time of service.

A. All reviewers must first identify member eligibility, and all decisions of this clinical policy are subject to current federal law. This Clinical policy does not constitute plan authorization, nor is it an explanation of benefits. In the event of a conflict, a member’s benefit plan, EOC, always supersedes the information in the Clinical Policies.

II. REGULATORY:

Code of Federal Regulations 42 (CFR) 422.112

Continuity of care. MA organizations offering coordinated care plans must ensure continuity of care and integration of services through arrangements with contracted providers that include—

- (1) Policies that specify under what circumstances services are coordinated and the methods for coordination;
- (2) Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer;
- (3) Programs for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the MA plan, including nursing home and community-based services, and behavioral health services; and

- (4) Procedures to ensure that the MA organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—
- (i) The MA organization makes a “best-effort” attempt to conduct an initial assessment of each enrollee’s health care needs, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment;
 - (ii) Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the MA organization, taking into account professional standards; and
 - (iii) There is appropriate and confidential exchange of information among provider network components.
- (5) Procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and
- (6) Systems to address barriers to enrollee compliance with prescribed treatments or regimens.
- (7) With respect to drugs for which payment as so prescribed and dispensed or administered to an individual may be available under Part A or Part B, or under Part D, MA-PD plans must coordinate all benefits administered by the plan and—
- (i) Establish and maintain a process to ensure timely and accurate point-of-sale transactions; and
 - (ii) Issue the determination and authorize or provide the benefit under Part A or Part B or as a benefit under Part D as expeditiously as the enrollee’s health condition requires, in accordance with the requirements of subpart M of this part and subpart M of part 423 of this chapter, as appropriate, when a party requests a coverage determination.
- (8)
- (i) With respect to basic benefits, policies for using prior authorization that at a minimum include that for enrollees undergoing an active course of treatment—
 - (A) Approval of a prior authorization request for a course of treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient’s medical history, and the treating provider’s recommendation; and
 - (B) A minimum 90-day transition period for any active course(s) of treatment when an enrollee has enrolled in an MA plan after starting a course of treatment, even if the service is furnished by an out-of-network provider. This includes enrollees new to a plan and enrollees new to Medicare. The MA organization must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days.
 - (ii) For purposes of this paragraph (b)(8), the following definitions apply:
 - (A) **Course of treatment** means as a prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan.
 - (B) **Active course of treatment** means a course of treatment in which a patient is actively seeing the provider and following the course of treatment.

III. DESCRIPTION

- A. This clinical policy should be utilized referencing the member’s specific Member Handbook to confirm the member’s coverage benefit(s).
- B. This policy defines the Sharp Health Plan (Plan) provision of continuity of care in compliance with CMS Final Rule 2024 for members receiving medical and behavioral health services during an active course of treatment for an Acute, Serious, or Chronic Medical or Mental Health Condition.
- C. This applies for new Medicare Advantage members who are undergoing an Active Course of Treatment with a Nonparticipating Provider at the time their coverage becomes effective with the Plan.

IV. DEFINITIONS

- A. Active Course of Treatment means a course of treatment in which a patient is actively seeing the provider and following the course of treatment.
- B. Course of Treatment means as a prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan.
- C. Prior Authorization: The process of a health insurance company reviewing medical necessity of a medical treatment or medication prior to approving. Other names for prior authorization are preapproval, precertification, or preauthorization. Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.
- D. Plan Medical Group (PMG): a group of physicians organized as or contracted through a legal entity, which has met the Plan's criteria for participation. A PMG has entered into an agreement with the Plan to make available, provide and/or coordinate professional services and the provision of other covered benefits to members on an independent contractor basis with providers who are included in the member's Plan Network.
- E. Plan Network: The network of providers selected by the employer or the member, as indicated on the member identification card.
- F. Newly Enrolled Member: an individual who enrolled with the Plan within the last 12 months.

V. MEDICAL NECESSITY

- A. Continuity of Care
 - 1. The Plan considers continuity of care an important component of the quality of care provided to our members. It is the intent of the Plan to comply with a member's request to continue to receive care from a nonparticipating provider until a safe transfer to the Plan contracted health provider can be made, consistent with good professional practice.
 - 2. For an Active course of treatment when member switches to the Plan as a new MA plan, the continuation of care will be provided for a minimum of 90 days.
- B. Prior Authorization
 - 1. For care that has been approved through prior authorization, approval is valid for as long as medically necessary to avoid disruptions in care. This is based on applicable coverage criteria and the member's medical history, and the treating provider's recommendation.
 - 2. Coordinated care plan prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary based on standards specified in the rule (not used for emergencies, or cannot be denied for the inpatient setting, or processes cannot be used to discriminate or direct members away from certain types of services.)
 - 3. If care is approved by prior authorization the plan cannot deny coverage later on the basis of lack of medical necessity.

VI. NOT MEDICALLY NECESSARY

- A. Continuity of care will not be provided by a provider whose termination was related to a medical disciplinary reason, fraud, Quality of care or other criminal activity.
- B. The Plan is not required to cover services or benefits that are not otherwise covered under the terms and conditions of the Plan contract.

- C. Continuity of care services are not medically necessary for conditions that do not meet the criteria delineated in this policy. (See Medical Necessity)
- D. Continuity of Care services will not be provided for providers who are not in good standing with CMS such as providers who are on the Preclusion list.

VII. PROCEDURE/ATTACHMENTS

- A. Review and confirm the member's coverage benefit for the member's specific member handbook regarding the section on continuity of care. Use the SHP Policy to adjudicate the member's COC request.
- B. If the Continuity of Care is for a pregnancy, a separate continuity of care request must be submitted for the newborn beyond care associated with the delivery and newborn hospitalization.
- C. Requests for continued care with a nonparticipating provider are reviewed by the Plan through its regular and appropriate utilization management review process and administered consistent with Plan benefit. This review shall include but is not limited to:
 - 1. Review of the member's health record.
 - 2. Review of other written or verbal supporting documentation from the member's out-of-network current health provider.
 - 3. Review of any written or verbal documentation submitted by the new member.
- D. The Plan shall issue a determination for each continuity of care request within the following timelines:
 - 1. Emergency-24 hours.
 - 2. Imminent and serious threat to member's health - <72 hours.
 - 3. Routine-14 business days.
- E. The Plan or Plan's contracted Medical Director or Physician designee issues the final determination on any denials of continuity of care requests. When a denial decision is made, it is faxed to the provider within one working day of the decision and the denial letter is mailed to the provider and the member.
- F. The Plan shall determine if there is a qualified provider within the member's network to assume the care of the member, and if equivalent services, including availability and frequency, are available. The member will be transitioned into the Plan contracted health provider's network following a Reasonable Transition Period with a minimum of 90 days if in active treatment. The Plan case management staff will facilitate transition of the member to the participating provider. This transition can include provision of the member's health record to the participating provider and/or appointment scheduling.
- G. All members approved for continuation of care with a nonparticipating provider will be referred to the Plan's case management program. The nonparticipating provider will submit a treatment plan to be reviewed by case management. Care will then be monitored on a regular basis to ensure that a safe and appropriate transition to a Plan contracted health provider can be made when the member's condition allows for such a transition within the timelines outlined in this policy.
- H. The amount of and the requirement for payment of copays, deductibles, or other cost sharing components by a Plan member during the completion of covered services with a non-participating provider are the same as would be paid by the member if he/she were receiving care by a Plan contracted provider.

VIII. CODES: N/A

IX. REFERENCES

- A. CMS Final Rule 2025 Utilization Management.
- B. Medicare Managed Care Manual Chapter 11
- C. Medicare Coverage Database.

X. REVISION HISTORY

Date	Modification (Original, Reviewed or Revised)
12/17/2025	Updated
12/18/2024	Updated
12/20/2023	Original

Approved by: (Signature of VP /CMO) 	Approval date: 12/17/2025
--	-------------------------------------