TRANSITION OF CARE

CONTINUITY OF CARE

Frequently asked questions

This resource is designed to give behavioral health care providers insight into the Transition of Care and Continuity of Care processes for their patients with Evernorth Behavioral Health coverage.

What is Transition of Care?
Transition of Care (TOC) allows a patient who is new to their plan to continue receiving care at in-network coverage levels for mental health or substance use disorder services from health care providers who are not contracted with Evernorth Behavioral Health. This care remains in place only until care can be safely transferred to a participating provider. The patient must apply for TOC at enrollment *or* refer to their Summary Plan Description for the time frame in which they need to request authorization.

What is Continuity of Care?
Continuity of Care (COC) may enable a patient to receive services at in-network coverage levels for a defined period of time for mental health or substance use disorder outpatient therapy, medication management, transcranial magnetic stimulation, applied behavioral analysis, and intensive outpatient program. For partial hospitalization program, inpatient, and residential, please call 800.926.2273.

COC would be appropriate under various circumstances, including:

- A patient's health care provider leaves their plan's network (patient must apply within 30 days of their provider's departure).
- Patient was notified by their employer that they may qualify for COC.
- A patient's employer changes health care plans and the immediate transfer of their care to another provider would be inappropriate and/or unsafe.

How does a patient apply for TOC/COC?
To apply for TOC/COC, the patient or the provider must send a completed TOC/COC request form to Evernorth Behavioral Health. The form should be submitted at the time of enrollment, change in plan, or when a patient's provider leaves the network. For TOC, the patient will need to refer to their Summary Plan Description for the time frame in which they need to request authorization. For COC, the request must be made within 30 days of their provider's termination date or after the patient has been notified by their employer that they may qualify for COC, unless federal or state law indicates otherwise.

To receive TOC/COC, the patient must already be receiving treatment for the condition indicated on the form. To receive in-network coverage for any other condition, the patient must receive care from a participating provider. If the patient's plan includes out-of-network coverage and they choose to continue out-of-network care beyond the time frame approved by Evernorth Behavioral Health, they must follow their plan's out-of-network provisions. This includes any precertification requirements.

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After receiving a TOC/COC request, we will review the information provided within 10 days and/or in compliance with state mandates. We will then send a letter to the patient informing them that their request was approved or denied. A denial letter will include information about how to appeal the determination. If the request is approved for behavioral health conditions, the patient will receive the in-network level of coverage for treatment for a defined period of time, as determined by Evernorth.

Please note that the availability of TOC/COC does not guarantee that a treatment is medically necessary and does not constitute precertification of the behavioral health services. Depending on the request, a medical necessity determination and formal precertification may still be required for a service to be covered.

Does a separate form need to be completed for each service?
Yes. A separate TOC/COC request form must be completed for each service for which the patient and/or their covered dependents are seeking coverage. In-network coverage levels provided as part of TOC/COC are for the specific service only and cannot be applied to another service. To ensure timely review of the request, it is important that all questions are answered in detail prior to submitting the form.

How much time is permitted for transitioning to a new participating health care provider?
If Evernorth determines that transitioning to a participating provider is inappropriate or unsafe for the conditions that qualify, services by the approved nonparticipating provider will be authorized for a specific period of time (usually 90 days). Or services will be approved until care has been completed or transitioned to a participating provider, whichever comes first.

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