Zing Health

TITLE: Continuity of Care- New Members

POLICY #: UM013_Continuity of Care-New Members
EFFECTIVE DATE: 1/1/2024
REVISED DATE(S): *NA*
POLICY DEPARTMENT: Utilization Management
AFFILIATED DEPARTMENTS: Operations-Claims
NEXT REVIEW DATE: 1/1/2026
AUTHORIZED OWNER: Vice President, Clinical Operations

POLICY STATEMENT: CMS requires Medicare Advantage Plans to have processes for ongoing courses of treatment for members who are new to plan to avoid disruption in services.

PURPOSE: The purpose of this policy is to establish guidelines and define a process to ensure that members have access to care related to ongoing courses of treatment when newly enrolled in a Medicare Advantage Plan.
Below describes the process to ensure that ongoing courses of treatment are maintained for new members.

1) Member/provider request- Transitions of care form in welcome kits for new members- all members receive a transition of care form that they can have their provider fill out and mail back to Zing Health. The form details the service the member is receiving, the length of time the service will be needed, and other pertinent information. If Zing receives the form, it is forwarded to the Utilization Management (UM) Department. The UM department will place a prior authorization and send the approval to the provider and member. This process includes services provided by out of network and in network providers. If the service is not covered by Medicare, the provider and member will be notified via the Integrated Denial letter which details the next steps.
2) Claims payment-Process for claims payment if a claim for a service is received and the date of service is within the first 90 days of the member's effective date:
    a. Providers submit a claim for services rendered
    b. Members who are within their first 90 days of their plan effective date, will have the claim pend to UM IF the service requires prior authorization
    c. UM staff will review the claim to determine if the service can be considered a current course of treatment or if a one-time service.

d. Services that are the current course of treatment will be released for payment for both par and non-par providers
e. Services that are one-time services such as radiology services that require prior authorization, will be reviewed for medical necessity.
f. Providers will be notified of the outcome of the claim payment by the claims processing team.

SCOPE: All Coordinated Care Medicare Advantage Plans, Chronic Special Needs Plans, Dual Special Needs Plans

APPLICATIONS: Salesforce/Health Rules Payor (HRP)

DEFINITIONS: NA

Special Instructions: NA

References:

CMS/MMCM:	2023 Final Rule (88 FR 22206), 2024 Final Rule
CFR:	§422.112(b)(8)(i)(B)
State Administrative Codes:	NA
Contract Requirements:	NA
Related Policies:	NA
Related Desk Level Procedures or Job Aids:	**NA**

POLICY ATTACHMENTS – N/A