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Originated Department	Clinical Operations

## Continuity of Care (COC)/Transition of Care (TOC)

### Audience

Wipro Health Plan Services (WHPS)  
 Personify Health  
 Mountain Health Co-Op

### Purpose

The purpose of this policy is to establish a consistent process for evaluating and responding to Continuity of Care and Transition of Care requests when a participating health care provider or facility leaves the network.

### Definition

Continuity of Care: See [COC Definition](#)  
 COC period: 90 days from the health care professional's termination date  
 Transition of Care (TOC): Transition of Care (TOC) refers to the process of transitioning medical care from nonparticipating health care professionals to participating health care professionals

### Policy/Procedure

Mountain Health Co-Op follows State or Federal regulations for continuity of care.

#### **MONTANA**

- Mont. Code Ann. § 33-36-201
- Mont. Admin. R. 6.6.5908 and 6.6.8829

When an insured provider is dropped from the network for any reason, an insurer shall establish reasonable procedures to transition the insured to a preferred provider that ensures continuity of care.

If the member requests it and the treating provider agrees that the member is in an active course of treatment, the treating provider may:

- (a) request that the members be permitted to continue treatment under the provider's care; **AND**
- (b) agree to accept the same reimbursement from Mountain Health Co-Op for that patient as provided for under that insurer's provider contract; **AND**
- (c) agree not to seek payment from the insured of any amount for which the insured would not be responsible if the provider were still a preferred provider.

(1) As used in this rule, "**active course of treatment**" means a condition which a provider reasonably believes could cause harm to an insured if care by the treating provider is suddenly discontinued, such as pregnancy or an ongoing course of treatment for an episode of cancer or other condition for which discontinuing care by the current treating physician may worsen the condition and interfere with anticipated outcomes.

(a) For a member in an active course of treatment, continuity of care must continue until the later of the following:

- (i) the ongoing course of treatment is completed; or
- (ii) through the postpartum period for a covered person in her second or third trimester of pregnancy.

(b) Except in the case of pregnancy, the continuity of care period may not last longer than 90 days, or the next renewal date for that policy, whichever is longer, without member consent; and

(c) Continuity of care protections are not required for routine primary and preventive care.

(2) Mountain Health Co-Op agrees to extend its obligation to reimburse the treating provider for ongoing treatment at the in-network rate if:

- (a) Mountain Health Co-Op agrees that the insured is in an "active course of treatment" as identified by the treating physician; and
- (b) The provider contract termination was not "for cause."

(3) Mountain Health Co-Op does not agree to extend ongoing treatment at the in-network rate, the insured may appeal that decision under the appeal rights outlined in the insurance contract. An expedited appeal process must be available.

## WYOMING

- WY Stat § 26-55-111 (2024)

On receipt of all necessary information documenting an authorization from the enrollee, previous health insurer or the enrollee's health care provider, a health insurer or contracted utilization review entity shall honor an authorization granted to an enrollee from a previous health insurer or contracted utilization review entity for not less than ninety (90) days after an enrollee's coverage under a new health plan commences, if the health care service is a covered benefit under the new health insurance plan.

During the time period described in subsection (a) of this section, a health insurer or contracted utilization review entity may perform its own review to grant a new authorization.

If there is a change in coverage of, or a change in approval criteria for, a previously authorized health care service under the enrollee's current health care plan, the change in coverage or

approval criteria shall not affect an enrollee who received authorization less than one (1) year before the effective date of the change. A health insurer or contracted utilization review entity may require a new prior authorization request one (1) year after the enrollee's previous prior authorization was requested.

No enrollee shall be required to repeat a step therapy protocol if that enrollee, while under their current or a previous health benefit plan, used the prescription drug required by the step therapy protocol, or another prescription drug in the same pharmacologic class with a similar efficacy and side effect profile or with the same mechanism of action, and discontinued use due to lack of efficacy, effectiveness, an adverse event or contraindication. The enrollee's prescribing provider shall submit justification and clinical information, if requested, that demonstrates a clinically valid reason for why the covered prescribed drug is needed and documentation of completion of previous step therapy protocols for the prescribed drug.

A health care provider, as identified by a unique national provider identifier, shall be granted a twelve (12) month or one (1) year exemption from completing a prior authorization request for a health care service, excluding the practice of pharmacy and prescription drugs, if:

- (i) In the most recent twelve (12) month period, the health insurer or contracted utilization review entity has authorized not less than ninety percent (90%) of the prior authorization requests, rounded down to the nearest whole number, submitted by the health care provider for that health care service; and
- (ii) The health care provider has made a prior authorization request for that health care service not less than five (5) times in the most recent twelve (12) month period.

A health insurer or contracted utilization review entity may evaluate whether a health care provider continues to qualify for exemptions as described in subsection (a) of this section. Nothing in this section shall require a health insurer or contracted utilization review entity to evaluate an existing exemption under subsection (a) of this section or prevent a health insurer or contracted utilization review entity from establishing a longer exemption period.

A health care provider is not required to request an exemption to receive an exemption under subsection (a) of this section.

A health care provider who does not receive an exemption under subsection (a) of this section may request from the health insurer or contracted utilization review entity up to one (1) time per calendar year per service, evidence to support the health insurer or contracted utilization review entity's decision. A health care provider may appeal to a health insurer or contracted utilization review entity's decision to deny an exemption.

A health insurer or contracted utilization review entity shall only revoke an exemption at the end of a twelve (12) month period if the health insurer or contracted utilization review entity:

Determines that the health care provider would not have met the ninety percent (90%), rounded down to the nearest whole number, authorization criteria based on a retrospective review of the claims for the particular service for which the exemption applies.

Provides the health care provider with the information it relied upon in making its determination to revoke the exemption; and

Provides the health care provider with a plain language explanation of how to appeal the decision.

An exemption under subsection (a) of this section shall remain in effect until the thirtieth day after the date the health insurer or contracted utilization review entity notifies the health care provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the fifth day after the revocation is upheld on appeal.

A determination to revoke or deny an exemption under subsection (a) of this section shall be made by a licensed health care provider that is of the same or similar specialty as the health care provider being considered for an exemption and has experience in providing the service for which the potential exemption applies.

A health insurer or contracted utilization review entity shall provide a health care provider that receives an exemption under subsection (a) of this section with a notice that includes:

A statement that the health care provider qualifies for an exemption from prior authorization requirements.

- (ii) A list of services for which the exemption applies; and
- (iii) A statement of the twelve (12) month duration of the exemption.

No health insurer or contracted utilization review entity shall deny or reduce payment for a health care service exempted from a prior authorization requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered such service received a prior authorization exemption, unless the rendering health care provider:

- (i) Knowingly and materially misrepresented the health care service in request for payment submitted to the health insurer or contracted utilization review entity with the specific intent to deceive and obtain an unlawful payment from the health insurer or contracted utilization review entity; or
- (ii) Failed to perform the health care service substantially.

Idaho does not have specific state-level continuity of care regulations. Mountain Health Co-Op follows the No Surprises Act Federal Law in this instance, which requires a 90-day transitional period at in-network rates when a provider leaves the network.

A member (enrollee) is considered a "continuing care patient" and may be eligible for the 90-day transitional period if they are:

- Undergoing a course of treatment for a serious and complex condition.
- Undergoing institutional or inpatient care.
- Scheduled for a non-elective surgery, including post-operative care.
- Pregnant and undergoing treatment for the pregnancy.
- Terminally ill and receiving treatment.

#### References

- Mont. Code Ann. § 33-36-201
- Mont. Admin. R. 6.6.5908 and 6.6.8829
- Wyo. Stat. § 26-55-111

#### Related Policies:

Continuity of Care (COC) Standard Operating Procedure (SOP)  
 NCQA 4B Continuation of Care

##### 1. Terminated

**1.1** The term "terminated" includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

##### 2. Related Policies:

**2.1** Continuity of Care (COC) Standard Operating Procedure (SOP)  
**2.2** NCQA 4B Continuation of Care

#### References

1. 42 USC 300gg-113: Continuity of Care
2. Mont. Code Ann. § 33-36-201
3. Mont. Admin. R. 6.6.5908 and 6.6.8829

#### Audience

Wipro Health Plan Services (WHPS)  
 Personify Health

#### Review/Revision/Approval History

Date	Description
01/01/2025	New Policy
12/16/2025	Added WY references
5/12/2026	Reviewed and Approved by the Policy Committee Updated NCQA requirements.

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