MEDICAL POLICY

Excellus

SUBJECT: DISABILITY DETERMINATION FOR EXTENSION OF BENEFITS AFTER CONTRACT TERMINATION **POLICY NUMBER: 10.01.11** **CATEGORY: Government Mandate**	**EFFECTIVE DATE: 08/26/10** **REVISED DATE: 08/25/11, 08/23/12, 06/27/13** **ARCHIVED DATE: 06/26/14** **PAGE: 1 OF: 3**

- ***If the member's subscriber contract excludes coverage for a specific service it is not covered under that contract. In such cases, medical policy criteria are not applied.***
- ***Medical policies apply to commercial and Medicaid products only when a contract benefit for the specific service exists.***
- ***Medical policies only apply to Medicare products when a contract benefit exists and where there are no National or Local Medicare coverage decisions for the specific service.***

POLICY STATEMENT:

I. Coverage for extension of benefits due to total disability after contract termination will be determined by the Health Plan Medical Director based upon the treating physician's certification of the former member's total disability at the time the contract terminated. The reviewing Health Plan Medical Director will review the medical criteria stated in the *Disability Evaluation under Social Security (Blue Book)*, published by the Social Security Administration, as a guide.

Certification of a member's total disability will be based upon the review of the former member's medical records and, if deemed necessary, discussion with the requesting physician by a Health Plan Medical Director or his/her appointed designee.

II. When it is determined, in the Health Plan Medical Director's sole discretion, a former member is totally disabled and an extension of benefits is available, benefits will be provided only for services directly related to the total disability.

POLICY GUIDELINES:

I. In order to be considered for extension of benefits due to total disability after termination of coverage, the total disability must have existed prior to termination of the contract.

II. Different standards apply to a determination of extension of benefits for individuals losing coverage under group contracts, versus individuals who lose coverage under individual, direct pay contracts. Please refer to the specific paragraph(s) in the Description section below for guidance.

DESCRIPTION:

Under the New York State Insurance and Public Health laws benefits are required to be extended for a former Health Plan member who is totally disabled at the time his or her subscriber contract terminates, in specified situations and periods of time.

According to Health Plan subscriber contracts when coverage under the contract ends, benefits stop. However, when a Health Plan Medical Director determines that a former member is totally disabled on the date his or her coverage under a certificate of coverage terminates, and the former member has received services or care for the illness, condition, or injury that caused his or her total disability while covered under the subscriber contract, extended benefits may be available as follows.

I. Former Member, Group Coverage:

A. When a former member covered through a group policy is totally disabled as of the date coverage terminates, extended benefits may continue for covered services to treat the total disability, if one of the following applies:

1. Termination of employment, eligibility, or contract: When a former member is no longer actively employed by the employer group providing coverage through the Health Plan, is no longer eligible for coverage under the contract, or the group contract terminates, extended benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date the coverage

ended. The hospital stay and/or surgery must be for treatment of the injury, sickness, or pregnancy causing the total disability.

2. Termination of active employment: Unless coverage is provided for services in connection with the total disability under another health plan, if group coverage ends because the former member is no longer actively employed, extended benefits will be provided during a period of total disability for at least 12 months from the date coverage ended for covered services to treat the injury, sickness, or pregnancy that caused the total disability.

3. Pregnancy: In addition to the requirements listed above, subscriber agreements providing benefits for hospital and/or medical expenses may provide benefits for covered expenses incurred as a result of pregnancy, childbirth, or related medical conditions if those conditions arise after termination of coverage, but as a result of pregnancy commencing while coverage is in force. If such benefits after termination of coverage are provided, it is not necessary to provide benefits for expenses incurred as a result of a sickness or injury commencing while coverage is in force if those expenses are incurred after termination of coverage, except as described above.

B. The extended benefits will terminate when all the benefits available have been exhausted, when a Health Plan Medical Director and/or his designee determines the member is no longer totally disabled or benefits are continued under paragraph A 2 above, and the member has reached the end of the 12-month period from the date coverage under the contract ended. We will never pay more than we would have paid had the member remained covered under the contract.

II. Former Member, Individual Coverage:

When a former member covered through an individual policy is totally disabled as of the date coverage terminates, extended benefits may continue for covered services to treat the total disability limited to the extent of the benefit period, if any, or payment of the maximum benefit. If no specific benefit period is provided, an extended benefit period of at least 12 months must be included in the contract. A loss shall commence when a medical service, whether or not covered by the policy, is rendered for the condition causing total disability.

CODES: Number Description

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

CPT: Several

HCPCS: Several

ICD9: Several

ICD10: Several

REFERENCES:

New York State Department of Financial Services. Compilation of Codes, Rules and Regulations of the State of New York. Title 11, § 52.17, 52.18.

*Social Security Administration Office of Disability. Disability evaluation under Social Security. SSA Pub 64-039. 2008 Sep [http://www.ssa.gov/disability/professionals/bluebook] accessed 5/6/14.

KEY WORDS:

Disability determination for continuation of benefits after contract termination.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

Based upon review, continuation of benefits for total disability after disenrollment from Medicare is not addressed in a National or Local Medicare coverage determination or policy.