Clear Spring Health

Utilization Management Program

2025

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Program Overview

The purpose of the Utilization Management (UM) Program at Clear Spring Health is to systematically monitor and evaluate services provided to our members across the healthcare continuum, while identifying opportunities for quality improvement, developing data- and evidence-based initiatives that target over and underutilization of healthcare services. This is a continuous process that involves internal UM staff, clinical practitioners, network providers, external business associates, and contracted vendors all operating under the auspices of a licensed physician. The goal of the UM Program is to ensure the provision of medically necessary care that produces optimal quality outcomes, cost efficiency, and coordination of care in compliance with Federal regulations.

The UM Program includes the review of medical and behavioral health services provided to members regardless of where services are provided within the U.S. or its territories. It also includes transition of care activities (i.e., discharge planning and post discharge follow up), health education, and support for the management of complex and long-term medical problems.

Prospective and concurrent reviews are performed to provide a basis for decision-making. This plan assures that UM decisions are made by qualified licensed healthcare professionals, who have the knowledge and skills to assess clinical information, evaluate working diagnoses, and proposed treatment plans. Inter-Rater Reliability (IRR) reviews are conducted to ensure consistent application of the utilization criteria by CSH Utilization Management staff annually. The Medical Director and other physician reviewers are assessed annually. The CSH Medical Director or designee oversees all UM activities and makes the final determination for denials based on medical necessity. All UM decisions are made in timely manner to minimize any disruption in the provision of healthcare services and to accommodate any clinical urgency.

UM vendors delegated for UM functions, including those functions related to behavioral healthcare (BH), must align their programs with the UM program and practices established by CSH and regulatory agencies. Delegates executing medical and/or BH UM functions are under the leadership of a Medical and/or Behavioral Health Medical Director.

Program Goals

Annually, the CSH UM program goals are reviewed and revised under the guidance of CSH's Medical Director. Overall program goals include:

1. Providing a mechanism to review services rendered to CSH members, ensuring these services take place in the most appropriate setting, based on evidenced based medical standards, and in the most cost-effective manner without compromising quality of care.
2. Promoting efficient utilization of services/resources.
3. Measuring the program's performance to identify gaps in care, network inadequacies, provider availability issues, and other opportunities for improvement.
4. Performing Inter-Rater Reliability (IRR) audits semiannually to ensure consistent application of criteria among utilization review staff.
5. Conducting an annual evaluation of the UM program by collecting and analyzing data from multiple sources; and, implementing appropriate interventions when opportunities for improvement are identified.
6. Referring eligible members to care management to assist with their continuity and coordination of care and achievement of members' optimal health outcomes.

7. Analyzing member and practitioner experience data and complaints, regarding the UM program, to identify opportunities and implement appropriate interventions to continuously improve services.
8. Working with other CSH departments to identify opportunities for collaboration to further organizational goals.
9. Collaborating with practitioners and providers in the active support of CSH members' rights as defined in the members' rights and responsibilities statement.
10. Ensuring UM program activities meet federal regulatory requirements.
11. Protecting the confidentiality of members' protected health information (PHI) and confidential information of practitioners and contracted vendors.
12. Managing adverse determinations in accordance with CMS regulations.

Scope

UM program activities interface with all CSH members, practitioners, providers, caregivers, health plan staff, health plan delegates, and vendors. The scope of UM activities includes the following:

1. Ensuring that quality health care that is medically necessary is delivered at the right time in the right setting.
2. Evaluating trends and patterns of utilization of health care services and acting on opportunities to improve resource utilization.
3. Directing the delivery of health care services to the appropriate setting through use of the following:
    a. Preservice authorization of services, items, or Part B drugs requests for medical and behavioral healthcare.
    b. Initial and concurrent review of admissions to acute care facilities, behavioral health facilities, rehabilitation facilities, skilled nursing, LTACH, and referrals for ambulatory and outpatient services.
4. Monitoring the delivery of medical and behavioral health services through the following activities:
    a. Review of medical and behavioral health care denials and appeals.
    b. Review of medical and behavioral health services to identify opportunities to improve continuity of care for CSH members.
    c. Review of provider and member experience ratings, complaints, and appeals regarding UM activities to identify opportunities to improve the UM program.
5. Conducting the following UM activities on an on-going basis to facilitate effective transitions and continuity of care:
    a. Discharge planning.
    b. Referrals to Care Management of members identified as eligible for care management and those members that may benefit from care management services.
6. Other activities include:
    a. Providing continuous education and performance feedback to UM staff.
    b. Quality improvement initiatives to improve the efficiency and effectiveness of the UM program.
    c. Continuous monitoring of delegates performing UM functions on behalf of CSH.

UM Committee Structure

The CSH Board of Directors has ultimate authority and accountability of the UM Program.
The QIC/UM Committee (The Committee) meets quarterly and serves as a steward of resources by assisting in the coordination of the overall operations of the UM program; recommending the adoption of evidence-based UM criteria, policies and procedures; reviewing and analyzing UM reports;

performing the annual evaluation of the UM program; and participating with long-term planning of the UM program. The Medical Director will serve as the Chairperson of the QIC/UM Committee and is ultimately responsible for implementation and management of the UM Program.

Committee membership includes:

1. Chair: Medical Director
    a. Internal Medicine Physician
    b. Family Medicine Physician
    c. Behavioral Health Physician
    d. Vice President, Health Services
    e. Vice President, Network Management
    f. Vice President, Quality Management
    g. Vice President, Pharmacy Operations
    h. Vice President, Enrollment and Member Services

At least annually, the QIC/UM Committee reviews, makes recommendations, and/or approves the following:

1. UM program, plan, goals, and objectives.
2. UM policies and procedures.
3. Evidence-based medical decision-making criteria and application process.
4. New or updated federal regulations related to UM procedures.
5. Provider and member complaints and other feedback.
6. Provider and member satisfaction survey results.
7. Results of Inter-Rater Reliability audits.
8. Over and under - utilization data.
9. New technology assessments and recommendations.
10. Results of network access and available studies.
11. Denial and appeal data.
12. Utilization statistics.
13. Case Management reports including participation rates.
14. Results of delegation audits.
15. Delegate UM plan review (annually).
16. Delegate UM statistical reporting (semi-annually).

The Committee makes program recommendations based on the following:

1. Performance on achieving established goals and objectives.
2. Changes in regulatory and/or accreditation requirements.
3. Provider and member feedback.
4. Changes to or status of the local delivery system including an analysis of out-of-network (OON) requests; loss of services that were previously available; addition of services that were previously unavailable; adequate availability, and access to services required by CSH's membership.
5. The Committee approves the UM program and votes to submit the approved program to the Board of Directors.

The Committee's activity is documented in the Committee's meeting minutes. The meeting minutes include the following:

1. Meeting date and time.
2. Members in attendance.

3. Agenda items discussed including content of the discussion, recommendations, action items, responsible party, and due dates for completion.
4. Chairman signature.

Use of UM Data for Quality Improvement Initiatives

Data collected through UM activities may be incorporated in CSH's QI initiatives when opportunities for improvement are identified. QI initiatives for the improvement of the UM program and activities are included in the annual Quality Management (QM) plan and reported to the Committee at designated intervals. New initiatives may be identified throughout the year; but are typically identified as result of the annual UM program evaluation.

Performance of the UM program is measured through the collection and analysis of several metrics that include the following:

1. Admits per thousand.
2. ER visits per thousand.
3. Bed days per thousand.
4. Average Length of Stay (ALOS).
5. Denial and appeal statistics.
6. Results of IRR audits.
7. Operational reporting including timeliness of UM decisions and prior authorization reports.
8. Results of provider and member experience regarding UM.

Delegation & Vendor Management

The Delegation Oversight Committee monitors delegation activities to ensure that delegated entities maintain compliance with regulatory and contractual obligations. There are four elements of delegation oversight:

1. Pre-delegation and/or Initial Delegation Assessments: Prior to initiation of the formal delegation agreement, CSH evaluates the financial viability and capacity of the entity to perform in accordance with expectations, business practices and all applicable state, federal and accreditation requirements. The pre-delegation assessment includes a review of the organizations' UM programs and related policies and procedures. Results of pre-delegation audits are presented to the Delegation Oversight Committee.
2. Delegation Agreements: The agreement describes the delegated activities and the responsibilities of CSH and the delegates in regard to these activities; required reports including the content of the reports, frequency of reporting, and how and to whom the reports are generated; the method by which CSH will provide the delegate with member experience data, if applicable, and clinical performance data or allow the delegate to collect their own data; provisions for PHI if applicable; stipulations regarding sub-delegation by a delegate; a description of the annual oversight process; and remedies available to CSH if a delegated entity does not fulfill the obligations specified in the delegation agreement, including revocation of the delegation agreement.
3. Annual Oversight Audits and Corrective Action Plans: CSH formally reviews the performance of delegated entities annually. The annual delegation oversight audit includes review of delegates' UM programs and related policies; UM file reviews including denial and appeal files; delegates' performance against CMS guidelines, and a review of delegates' performance in meeting reporting requirements and results of reports. Results of annual oversight audits are presented to the Delegation Oversight Committee.

The Delegation Oversight Committee may:

a. Approve continued delegation,
b. Recommend the implementation of a corrective action plan, or,
c. Suggest termination of the delegation agreement.

4. Ongoing Oversight: CSH conducts ongoing oversight of all delegated entities in accordance with established reporting timeframes. This includes review of the material content and performance of the delegated entity on delegated activities as documented in report submissions, e.g., meeting required UM decision timeframes, results of IRR audits, satisfaction with delegates' UM programs.

The UM department takes an active role in the evaluation of UM delegates through:

1. Regular analysis of required UM statistic reports.
2. Periodic monitoring of completed events, including denials and appeals.
3. Providing feedback of the delegate's performance issues to the delegate and the Delegation Oversight Committee.
4. Annual review of delegate(s) UM Plan/program description, policies, UM decision criteria by the Delegation Oversight Committee.
5. Semi-annual review of UM statistics by the Delegation Oversight Committee.

(See Appendix A for how CSH delegates UM functions)

Utilization Management Structure, Roles, and Responsibilities

The CSH UM department is comprised of a physician reviewer(s), UM Specialists, and UM Intake Coordinators. The UM Specialists are responsible for coordinating the utilization review of medical and behavioral health services for:

1. In-network and out-of-network inpatient admissions.
2. Discharge planning/Transition of Care activities.
3. Post-acute placement.
4. Outpatient services, items, or Part B drugs requests.

The UM Specialists also make appropriate referrals to care management services.

CSH UM staff share responsibilities with UM delegates for these activities, as described in delegation agreements.

The CSH UM division employs qualified licensed professionals to supervise all medical necessity decisions. Qualified supervisors are licensed registered nurses, have utilization management experience, accreditation and/or other regulatory requirements for CSH lines of business.

Job descriptions specify the level of UM decision-making that can be made by each level of clinical staff. All clinical staff involved in UM decision-making are required to have current, unrestricted nursing licensure.

Denials based on medical necessity are made by CSH's Medical Director, Medical Director's Physician reviewer designee or delegates' Medical Directors, if this function is delegated. Pharmacists may make denials based on medical necessity for pharmaceutical denials. This function must be described in the job descriptions of individuals making these decisions. All practitioners involved in making denial decisions based on medical necessity are required to have education, training and/or professional experience in medical or clinical practice and a current clinical license to practice or an administrative license to review UM cases.

Non-clinical staff collect information and may utilize explicit criteria to make determinations, when applicable and per CSH policy, e.g., in-network observation stay up to 23 hours that are auto-approved.

UM decision-making at CSH is based solely on appropriateness of care and service and existence of coverage. CSH does not reward UM staff, practitioners, or other individuals for issuing denials of coverage. Any financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Medical Director

The Medical Director assists in CSH's clinical services including manages day to day utilization management, care management, and quality improvement activities, provides clinical expertise needed to effectively resolve clinical and administrative circumstances in the Health Services Department, provides expert medical education, consultation, and supervision for the clinical staff, works cooperatively with the CSH staff, providers and vendors, and participates in CSH's Credentialing and Re-credentialing process.

1. Manages the day-to-day quality improvement, utilization management, and care management activities.
2. Assures all internal and vendor medical review activities conforms to company protocols, customer requirements, and professional standards.
3. Works closely with other physician reviewers and clinical services staff to attain and/or maintain compliance with company, customer, accreditation, and regulatory requirements.
4. Reviews and makes determinations regarding medical necessity.
5. Consults as appropriate with practitioners in determining utilization decisions.
6. Identifies those instances where the competence or conduct of a physician or other health care provider has an adverse effect on the patient care (and/or the goals of CSH) and takes appropriate action.
7. Reviews potential quality issues, appeals and grievances related to medical quality of care. Participates in Utilization Management and Care Management rounds. Monitors care and services through continuum among hospitals, skilled nursing facilities, and home care to ensure quality, cost-efficiency, and continuity of care.

Provides expert medical education, consultation, and supervision for the clinical staff. Review and completes up to date credentialing and re-credentialing files prior to presentation to the Credentialing Committee. Chairs the QIC/UM and Credentialing Committees.

Vice President of Health Services

The VP, UM reports to the Chief Operating Officer and in collaboration with the Medical Director, the VP, UM oversees all functions and reporting responsibilities of the Utilization Management Program. Key functions of the VP, UM include:

1. In collaboration with the Medical Director, serves as an executive sponsor for focused studies and improvement initiatives.
2. Oversees the design of policies and procedures that affect service delivery and standards of care.
3. Approves the staffing plan and resources allocated to integrate the UM Program toward achievement of organizational goals and objectives.
4. Oversees delegated functions.
5. In collaboration with designated staff, oversees and manages follow-up on recommended actions.

6. Serves as a resource for CSH management and staff.
7. Provides leadership and contribution to interdisciplinary activities within the organization.

Utilization Management Team Lead

- Manages and resolves human resources, employee, department safety, and risk management issues. Responsible for all aspects of staff management including hiring, development/training, performance reviews, and terminations.
- Develops and implements policies to reinforce high quality, efficient workflows.
- Ensures that review requests are performed using Medicare guidelines and, in its absence, nationally recognized and evidence-based standards such as Milliman Guidelines.
- Ensures that authorizations are entered into the UM system in a timely fashion and within mandated timeframes.
- Provides prior authorization, discharge planning, and transition of care coverage in the event of staffing shortfalls.
- Ensures that members are notified of any denials in a timely and culturally competent manner in accordance with contractual mandates and accreditation standards and ensures that members are notified of appeal rights.
- Investigates and follows up on complaints, grievances, and quality issues related to CSH utilization management functions.
- Assists the VP of Health Services in preparation for audits and other regulatory issues.

Utilization Management Specialist

The Utilization Management Specialist is a licensed Registered Nurse responsible for performing all utilization management activities to include reviewing, screening, processing, and authorizing pre-service requests and admissions. Key functions of this position include:

1. Performs prospective, initial, and concurrent reviews for requested covered services.
2. Assesses members' clinical status against established guidelines to ensure that members receive appropriate levels of care in appropriate settings and that the length of stay meets the needs of members.
3. Participates in the discussion and notification processes that result from the clinical utilization reviews with members, facilities, and service providers.
4. Prepares compliant notification letters of non-certified and negotiated days and services within established time frames. Reviews all non-certification files for correct documentation.
5. Works closely with facility Discharge Planners to coordinate required resources and care post-discharge.
6. Identifies members for potential inclusion in the care management program.
7. Participates in ICT meetings for the SNP membership.

Intake Coordinator

The Intake Coordinator provides non-clinical support for the UM activities. Key functions include:

1. Using pre-screening referral and service request forms to capture all necessary data elements to support requests.
2. Verifying eligibility and coverage for the requested services.
3. Entering admission notifications and referral requests into CSH's documentation system.
4. Transferring UM files to the appropriate UM Specialist.
5. Approving routine service/referral events that require no clinical judgement using explicit criteria per CSH policy (i.e., services that are auto approved such as office visits to in-network Specialists).

6. Assisting with member communication orally and in writing of approved UM decisions.
7. Reviewing UM reports to monitor notification of approvals and denials to members, members' representatives and providers.
8. Faxing notification of admissions and discharges to primary care providers.
9. Fax communication routing and other clerical functions as assigned.

Access to CSH UM Staff

CSH UM staff normal business hours are 8:30 am to 5:00 pm CST, Monday through Friday, and Saturday from 9 am to 1 pm CST, except during scheduled closings for holidays. CSH staff are available to members, members' representatives, and providers eight hours a day during normal business hours for inbound collect and toll-free calls regarding UM issues. Members can access the UM staff by calling the phone number on the back of the member's card. During normal business hours, CSH UM staff are responsible for pre-service reviews, notification of admissions and concurrent reviews. Member services staff answers questions by reviewing the system entries. If questions cannot be answered in this manner, the calls are transferred to the UM area for management.

The UM staff receives inbound messages after normal business hours regarding UM issues via voicemail. Outbound communications from staff during normal business hours occur via telephone, fax, secure email, and/or voicemail. TTY services are available for deaf and hearing-impaired members. Language assistance is available through bilingual staff and translation services. All communication and language assistance services are free of charge. Members are notified of this in the Evidence of Coverage.

UM staff makes outreach attempts to providers within one business day from receipt of communication. Each staff member has confidential voicemail to receive UM questions and issues during and after hours. The UM staff identify themselves by name, title, and organization name when initiating or returning calls.

Member and Provider Communication

CSH provides regular communications with members and providers to disseminate information about UM activities. In addition to telephonic, email, and fax communications, other communication tools include:

1. Provider manual.
2. Provider notices.
3. Evidence of Coverage.
4. CSH's website.
5. Fax and/or email (upon request).
6. Direct contact during office visits by Network Management Representatives.

Necessary Clinical Information: Medical and BH UM Reviews

UM and intake staff receive inpatient and outpatient service requests via phone, fax, provider portal, or e-mail. Pre-service Notification and Admission Notification forms are available to providers on the website for optional use.

To support UM decision making, the UM staff and/or Medical Director gather, and document relevant clinical information obtained from the attending physician or requesting provider. CSH limits the collection of information to that necessary to certify admissions, procedures, and treatments. Relevant clinical information may include medical history, lab tests, progress notes, operative reports, medical necessity letters, x-ray reports, and information specific to individual members, e.g., age, co-morbidities, complications, treatments, psychosocial situations, and assessments of home care environments, including caregiver resources.

The UM decision-making licensed professional also considers characteristics of the local health care delivery system available to meet members' needs including:

1. The availability of skilled nursing facilities or home care in CSH's service area to support the patient after hospital discharge.
2. The coverage of benefits such as skilled nursing facilities or home care when needed.
3. The ability of local hospital(s) to provide recommended services within the estimated length of stay.
4. The availability of ancillary providers to provide recommended services after discharge.

Medical Necessity Criteria for Medical and Behavioral Health

CSH and its delegates utilize CMS National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) to make UM decisions. These criteria encompass medical, surgical, outpatient surgery, behavioral health services including mental health and substance use disorders, rehabilitation, home health (HHA), comprehensive outpatient rehabilitation facilities (CORF), and skilled nursing facility (SNF) placements.

CSH's QIC/UM Committee approves all criteria used to make medical and BH UM decisions including those used by delegated entities at least annually. CSH and Delegates may employ the reference of internally developed criteria provided they adhere to the following guidelines:

1. All medical and behavioral health criteria used by CSH, CSH Delegates, and Sub-Delegates are subject to annual review and approval by the QIC/UM Committee.
2. Criteria review and approval is documented in the QIC/UM Committee meeting minutes along with relevant research contributing to its approval and concurrence by at least one UM Committee Member.
3. *(For Delegates)*: Medical and behavioral health criteria used by CSH's Delegates are submitted to CSH's QIC/UM at least annually as specified in delegation agreements.

The CSH Medical Director may make medical determinations using other nationally accepted and evidence-based guideline indexes and literature such as Medicare Manual, nationally accepted UM criteria such as Milliman Care Guidelines (MCG), the National Guidelines Clearing House (NGC) when there are no applicable NCDs, LCDs, or MCG criteria.

For situations where nationally recognized evidence-based criteria are not available, CSH may develop its own guidelines using the best scientific evidence available. The development process of the criteria includes input from appropriate specialists and practitioners that are likely to use the guideline. Criteria developed by CSH must be reviewed and approved by the QIC/UM Committee. Documentation of review and approval by the QIC/UM Committee must be noted in the meeting minutes. The Delegates may adopt additional criteria, clinical pathways, and/or guidelines that have been reviewed by their QIC/UM Committee and chosen, based on the best available medical evidence. Delegates must describe their process for the development and adoption of guidelines when a national guideline is not available. Discussion of how the additional criteria, clinical pathways, and or guidelines were developed or selected must be identified in delegates' UM programs as part of the criteria approval process.

Availability of Criteria

CSH publishes the internal coverage criteria, explains the reasoning behind the policy's adoption, and compiles the data and sources that were utilized to develop the criteria.

By granting secure password or secured portal access to the clinical criteria utilized for the case, CSH leverages MCG Cite for Guideline Transparency to share the medical necessity criteria used in the

context of an adverse decision. Using Cite for Guideline Transparency, CSH can inform health plan members and healthcare providers about the clinical indications. A handful of the guidelines' features are displayed, including the clinical indications and the evidence summary.

Medical and Behavioral Healthcare Determinations

Only the CSH Medical Director, Physician reviewers or other designated practitioners at delegated entities may deny care or services based on medical necessity. CSH delegates must meet the timeframes and guidelines specified in CSH's UM program to meet CMS requirements. Annually, CSH distributes a statement to all members and to all practitioners, providers, delegates, and employees who make UM decisions that affirms the following:

1. All UM decisions are based on the appropriateness of care and service and the existence of coverage.
2. CSH and its UM Delegates do not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives, if offered to UM decision-makers, will not encourage decisions that result in underutilization.

UM Decision and Notification Timeframes

CSH and its UM delegates, make UM decisions and provides notification of the decisions per the following timeframes:

- Standard requests of services and items – fourteen (14) calendar days from receipt date.
- Expedited requests of services and items – seventy-two (72) hours from receipt date and time.
- Standard requests of Part B drugs – seventy-two 72 hours from receipt date and time.
- Expedited requests of Part B drugs – twenty-four 24 hours from receipt date and time.

Expedited requests, concurrent – seventy-two (72) hours: Concurrent requests for Medicare members hospitalized in an acute care setting are treated as expedited requests.

For standard requests, the processing timeframe begins when the plan, any department in the plan, or a delegated entity (including a delegated entity that is not responsible for processing) receives a request. For expedited requests, the processing timeframe begins when the UM department receives the request.

Written notification is considered delivered on the date (and time, if applicable) the plan or delegated entity has deposited the notice in the courier drop box (e.g., U.S. Postal Service, UPS, DHL, or FedEx).

Inter-Rater Reliability Testing

Inter-Rater Reliability (IRR) testing ensures consistency in the application of nationally recognized medical criteria and is administered to all staff making UM decisions, including Physician reviewers. At least annually, the QIC/UM Committee will assess IRR audit results and document its findings in the committee meeting minutes. Inter-Rater Reliability testing is administered by a licensed professional peer of the individual being tested. All examinees must pass with a score of at least 85%. If an individual does not pass with a score of 85%, he or she will be given additional education in the areas missed and allowed to retake the examination. Further education is on a case-by-case basis. If the application of criteria is not consistent across staff, there is discussion in the QIC/UM Committee meetings regarding the files, along with corrective and/or disciplinary actions, if necessary.

Preservice (Prior Authorization) Review

Preservice utilization review is the process by which medical/behavioral healthcare services are assessed for medical appropriateness prior to their delivery using CMS guidelines or other approved nationally recognized criteria. The UM staff or delegate UM staff determines member eligibility, benefit coverage,

and medical appropriateness when making UM determinations. Determinations on non-urgent preservice requests are made within 14 calendar days of receipt of the request or 72 hours for Part B drugs. Because of the time frame given, this must be a non-urgent preservice request. Determinations on urgent preservice requests are made within 72 hours or 24 hours for Part B drugs of receipt of the request.

CSH maintains a list of inpatient, outpatient, and ancillary services that require Preservice Authorization, for a current list refer to CSH website.

All members have direct access to covered preventive services; there is no Preservice Authorization required for these services.

Out-of-area urgent and emergent care is covered without preservice authorization. Renal Dialysis services are covered without preservice authorization when the member is temporarily outside of the plan's service area.

Extension of Timeframe

CSH may extend the 72-hour or 14 calendar days timeframes by up to 14 days if:

- The member requests the extension; or
- The extension is justified, in the member's interest, and additional medical evidence from a non-contract provider is needed to make a decision favorable to the member; or
- The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the member's interest.
- Part B drugs timeframes cannot be extended.

The plan decision to extend a preservice request for services or items must be notified to the member in writing. The notification includes the reasons for the delay and an explanation of the member's right to file an expedited grievance if member disagrees with the extension.

Initial Admission and Concurrent Reviews

Initial admission and continued stay review decisions and notifications are made within seventy-two (72) hours of receipt of the request. CSH documents that it made at least three attempts to obtain the necessary information to make a UM decision before issuing a denial notice.

Board Certified Consultants/Advisory Panel

CSH contracts with an Independent Review Organization (IRO) to consult with board certified physician specialists to assist the Medical Director and other physician reviewers, including UM delegates' Medical Directors or designated physician reviewers in making UM decisions that require same or similar specialty review. The referral to and recommendations from board certified consultants are documented, included in the UM file, and tracked for trending and quality purposes.

Discharge Planning & Follow Up After Hospitalization

Discharge planning is the process by which the UM Specialist plan for the member's discharge in collaboration with the health care delivery team and the member/caregivers. Discharge planning begins at the time of the pre-admission certification and/or admission to the hospital and continues through the inpatient confinement. The objectives of discharge planning are:

1. To facilitate timely and appropriate discharge of confined members.
2. To evaluate alternative levels of care.
3. To provide information about available community resources.

4. To support the delivery of quality, cost effective health services; and to direct services to contracted providers.

The UM Specialist makes appropriate referrals to Care Management services. Discharge follow-up by telephone is conducted by Care Coordinators within 5 business days following notification of discharge. The purpose of the post discharge call is to:

1. Re-confirm that all discharge needs are in place (e.g., DME has been delivered, admission to home health is established, etc.).,
2. Determine if the member understands post discharge instruction,
3. Clarify any questions regarding self-care or other health care questions,
4. Verify that physician follow up visit scheduling is understood, and
5. Determine transportation needs (if any) for follow-up visits.

After a member discharges, CSH could use a vendor to follow up with the member. Following discharge, the vendor will offer the following services:

- Visits to homes by vendor practitioners.
- For 30-days following discharge, a personalized care plan with Care Guide support is provided. Setting up follow-up visits, assisting with the acquisition of DME, locating community resources, providing education on the member's medical conditions, and other services are examples of member assistance.

Adverse Determinations

All requests for clinical services that do not meet CSH's or delegates' medical necessity criteria or are considered experimental/investigational are reviewed by CSH's Medical Director or other physician reviewers, including UM delegates' Medical Directors or designated physician reviewers. When a request is denied, CSH notifies the member, member's representative, referring provider, and/or the treating practitioner in writing.

Denial files include the clinical information used to make the decision and the following documentation:

1. Dates additional clinical information was requested and received or documentation that requested information was not received.
2. The date the information was forwarded to the physician reviewer to make a determination.
3. Documentation of the physician reviewer's specific reason for the denial, including criteria used, lack of medical necessity, or lack of sufficient information to approve the request.
4. The physician reviewer's name.
5. Date and time the member was notified of the adverse decision.
6. Copies of all written notifications to providers.

CSH and its Delegates' written notification of denials includes the following:

1. The specific reasons for the denial, in easily understandable language.
2. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.
3. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.
4. An explanation of the appeal process, including members' rights to representation and appeal time frames.
5. A description of the expedited appeal process for urgent preservice or urgent concurrent Denials.
6. Notification that expedited external review can occur concurrently with the internal appeals

process for urgent care.

The organization must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to members receiving covered skilled nursing, home health, and comprehensive outpatient rehabilitation facility services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Adverse determinations are tracked for quality and UM program analysis.

Selecting the Provider of Services

CSH will not designate a particular provider to perform medical services that are available from a variety of provider types. For instance, CSH cannot require SNF care over IRF care if the patient is eligible for treatment at an inpatient rehabilitation facility (IRF) or skilled nursing facility (SNF). CSH may alert the member to potential alternatives but may not make decisions on behalf of the member on the kind of service provider that must be chosen.

Emergency Services

CSH provides coverage for emergency medical and behavioral health conditions. A medical or behavioral health emergency is defined as one with acute symptoms of sufficient severity, including but not limited to severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the lack of immediate medical attention to result in:

1. Serious jeopardy to the person's health (or unborn child's health).
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Members who feel their condition or situation is serious are instructed to go to the nearest hospital, call an ambulance or 911. Prior authorization/approval for medical or behavioral health emergency services is not required.

Post- Stabilization Service

Post stabilization services are services related to an emergency medical condition that are provided after the member’s immediate medical problems are stabilized. Emergency services do not require prior authorization. Examples of post-stabilization services that require pre-authorization are outpatient out-of-network services, non-emergent inpatient admissions, non-contracted hospital services, and skilled nursing facility admissions. CSH will cover post-stabilization services provided by an affiliated or non-affiliated provider in any of the following situations:

1. CSH authorized the services.
2. Services were administered to maintain the members stabilized condition within one (1) hour after a request to CSH for authorization of further post-stabilization services.
3. CSH does not respond to a request to authorize further post-stabilization services within one (1) hour.
4. CSH could not be contacted.
5. CSH and the treating provider cannot reach an agreement concerning the member’s care and an affiliated provider is unavailable for a consultation. In this case, the treating provider is permitted to continue the care of the member until an affiliated provider is reached and either concurs with the treating provider’s plan of care or assumes responsibility for the member’s care.

Out of Network Admissions

Out-of-Network admissions are urgent or emergent admissions to hospitals that are non-contracted with CSH and occur without prior approval. As soon as CSH or its delegates becomes aware of the admission, the UM staff obtains an initial review, patient information and:

1. Monitor of care to determine when the member is stable for transfer or discharge.
2. When stable, facilitate the transfer of the member to an in-network facility.
3. Contact the member concerning the decision to transfer and answer any questions and concerns.
4. Document all member refusals to transfer and refer the case to a UM physician reviewer for a determination.

Two-Midnight Rule

Clear Spring Health will adhere to the Two-Midnight Rule for medical and psychiatric inpatient admissions unless a one-day inpatient stay is judged required based on a patient's unique medical condition and comorbidities, or unless the admission is for a procedure on the Inpatient Only List.

Skilled Nursing Facility 3-Day Rule

The 3-day rule requires the patient have a medically necessary 3-day-consecutive inpatient hospital stay.

If a patient has a qualifying inpatient stay in a hospital for a minimum of three calendar days in a row, beginning on the day of admission and ending on the day of discharge, CSH will pay for SNF services.

The day of discharge, any ER time prior to admission, or outpatient observation are not included in the 3-day consecutive stay total.

Out of Network Pre-Service Requests

Members may request a referral to receive services from an out of network provider or vendor when CSH's provider network is unable to provide service in required timeframe or the plan doesn't have the specialty in the network. UM staff will secure relevant clinical information, discuss letters of medical necessity (when applicable), locate, and secure a network provider for the services requested. The review timeframe for out of network services are: 72 hours for the urgent preservice request and 14 calendar days for the standard preservice request. If services cannot be located in-network, UM staff will facilitate an out of network approval by referring the request to CSH's Medical Director or physician advisor. When services are determined necessary and appropriate, the UM Specialist notifies CSH's Network Management Department for the processing of a Single Case Agreement. Written communication of all CSH approved services is provided to the requesting provider and the member.

CSH has a PPO line of business which means certain services can be covered by either an in-network or out-of-network provider. If PPO members decide to use their out-of-network benefit, the part that they are required to pay may be higher.

Second Opinion

Members have the right to request a second opinion through their PCP, Medical Group or by calling member services. The provider whom the member wishes to consult with for a second opinion must be a contracted CSH provider. If a particular specialist is not available in network, CSH will approve the consultation with an out of network specialist for the second opinion only.

Continuity of Care

CSH ensures continuity of care for prospective, new, and current members.

New Members

CSH ensures continuity of care for new members whose physician is not a contracted provider in CSH's provider network; but is within CSH's service area. CSH shall permit the member to continue the ongoing course of treatment with the member's current physician during the transitional period under the following guidelines:

1. An approval will be granted through the prior authorization process, and it will be valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation. A minimum of a 90-day transition period will be provided when an enrollee who is currently undergoing an active course of treatment switches to CSH.
2. The member has entered the second trimester of pregnancy at the effective date of enrollment including the delivery and the provision of post-partum care.
3. To accept reimbursement from CSH at established rates; such rates will be at the level of reimbursement applicable to similar providers within the CSH network of services.
4. The provider agrees to adhere to CSH's policies and procedures regarding coverage determinations.

Current Members

CSH ensures continuity of care for its members if a CSH physician leaves CSH's network for reasons other than:

1. Termination of a contract in situations involving imminent harm to a patient; or
2. Final disciplinary action by State licensing board.

CSH will allow members continued access to their practitioner, in the following situations:

1. Ninety (90) days from the date of the physician's termination if the member is engaged in an active ongoing course of treatment.
2. The member is in the second and third trimester of pregnancy at the time of provider's disaffiliation with the health plan. CSH will authorize services for the remaining prenatal care visits, the delivery, and the post-partum care.
3. The physician agrees to continue reimbursement from CSH at the rates applicable prior to the start of the transitional period.
4. The provider agrees to adhere to CSH's policies and procedures regarding coverage determinations.

CSH will engage the member to develop a safe transition plan to a CSH contracted provider.

Behavioral Health

CSH seeks to deliver comprehensive, timely, and appropriate behavioral health services in compliance with member's benefits and CMS requirements. CSH's behavioral health services include:

1. A Behavioral Health network adequate to serve the Behavioral Healthcare needs of members.
2. Behavioral Health and substance abuse services sufficient to provide care within the community in which the members reside.

3. Provide assistance in Behavioral Health services, including but not limited to transportation.
4. Member's access to timely Behavioral Health services.
5. Coordination of care between providers of medical and Behavioral Health services to assure follow-up and continuity of care.
6. Involvement of the PCP in aftercare.
7. Assessment of the member's satisfaction with access to and quality of Behavioral Health services.
8. Behavioral healthcare outpatient and inpatient utilization and follow up.
9. Chemical dependency outpatient and inpatient utilization and follow up.

Assessing Experience with UM Process

Clear Spring Health annually assesses both member and provider experience with the UM process by evaluating data from surveys and/or complaints and appeals data. Identifiable sources of dissatisfaction are addressed through process improvement activities to meet goals and objectives for the UM department.

Clinical Trials

CSH covers routine services that would normally be provided if the member were not in a clinical trial. Other costs are generally not covered. For more information refer to CMS National Coverage Determination (NCD) 310.1 for routine costs in clinical trials.

Transplant Services

CSH covers transplants which meet Medicare guideline. Coverage decisions will be made in accordance with CMS National Coverage Determinations. Pre-authorization by CSH for the transplant evaluation and procedure is required.

Benefit Coverage, Benefit Limitations, and Medical Necessity Determinations

CSH maintains lists of covered services for inpatient and outpatient services based upon CSH's contract with CMS. The list includes information on covered services, any limitations on covered services, benefit coverage and those services requiring prior authorization for medical necessity by UM. The lists are available electronically on the company shared CSH computer drive and on the CSH website, as well as in the Evidence of Coverage. UM staff are educated to refer to covered services lists as resources for any questions regarding benefit coverage. Other resources UM staff use as resources for benefit coverage include but are not limited to CMS guidelines.

Requests for services beyond the covered services or beyond any limitations in covered services require review by the Medical Director or designee for final determination of coverage.

Vision Benefits

CSH partners with EyeQuest for administering vision care benefits and UM review of vision care services. At the members' or vision care providers' request, vision service requests resulting in an adverse determination may be reviewed by the CSH Medical Director or delegate Vision Director for coverage by CSH. The decision-making process for these services adheres to the preservice review guidelines previously outlined in this document.

Dental Benefits

CSH partners with DentaQuest for administering dental care benefits and UM review of dental services; including services rendered by oral surgeons. At the members' or dental care providers' request, dental service requests resulting in an adverse determination may be reviewed by the CSH Medical Director or delegate Dental Director for coverage. The decision-making process for these services adheres to the preservice review guidelines previously outlined in this document.

Pharmaceutical Management

The CSH Pharmacy Utilization Management (UM) program is designed to encourage safe and effective drug utilization, help enhance plan members' health outcomes and promote cost-effective drug benefits plan design. The UM program includes requirements set forth by the Centers for Medicare and Medicaid Services (CMS) and other applicable regulatory organizations. The CSH Director of Pharmacy serves as the liaison between CSH and PBM associates on matters of policies and procedures, clinical criteria justifications, and defined roles and responsibilities for prior authorization and coverage determination decisions.

CSH's pharmacy benefits are delegated to Optum Rx. CSH adopts Optum Rx UM Program. The UM program criteria are based on standards of medical practice, current clinical principles and processes of pharmacotherapy, evidence-based drug information, expert opinion from published guidelines and consensus statements, as well as information from other published literature such as those published in drug labeling approved by the U.S. Food and Drug Administration (FDA) and other recognized compendia. Other appropriate resources include randomized clinical trials, pharmacoeconomic studies and outcomes research data. The Pharmacy UM Program will be reviewed at least annually by the CSH Pharmacy Director and Medical Director, and or more frequently when new indications or safety information for the drug or drug class changes. In these situations, the program is updated.

CSH adopts our PBM's standard Prior Authorization Protocols (PA), Quantity Limits, and Step Therapy criteria for our Pharmacy UM programs as the most efficient means for implementing and maintaining clinically current coverage conditions. CSH reserves the right to submit custom criteria to support unique aspects of our plan design. In addition, CSH may select the drugs to include in CSH's plan design. CSH approves (or modifies) and accepts selected UM criteria before implementation by the PBM. CSH may request the development of custom coverage criteria that are reviewed by the PBM's medical directors, pharmacists, and appropriate clinical personnel.

CSH reviews and approves the PBM's policies and procedures for pharmaceutical management. These policies and procedures specify the criteria used when adopting pharmaceutical management procedures; the use of clinical evidence for pharmaceutical decisions; the involvement of appropriate practitioners and the distribution of pharmaceutical management procedures.

CSH annually and after updates, communicates to members and prescribing practitioners, the list of pharmaceuticals, including restrictions and preferences, how to use the pharmaceutical management procedures, an explanation of limits and quotas, the requirement for prescribers to provide information to support exception requests, and the processes for generic substitution, therapeutic interchange, and step therapy protocols.

The PBM monitors potential safety issues and notifies affected members and prescribing practitioners of identified concerns, including Class II and voluntary drug withdrawals from the market for safety reasons

within 30 calendar days of FDA notification. The PBM also reviews and adopts an expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.

CSH reviews and accepts the PBM's annual review of procedures, the list of pharmaceuticals, appropriate updates as procedural changes arise, and updated lists of pharmaceuticals as appropriate.

CSH reviews and accepts the PBM's exceptions policies and procedures for making exceptions based on medical necessity, obtaining medical necessity information from prescribing practitioners, using appropriate pharmacists and practitioners to review exception requests, timely handling of requests, and notification of reasons for denials and an explanation of the appeal process when an exception is not approved.

CSH delegate's responsibility for denial and appeal of UM decisions to Optum Rx. CSH accepts the processes established by Optum Rx that gives providers the opportunity to discuss UM denial decisions with a physician or pharmacist. The written notification of pharmacy denial is sent to members and their treating providers. It contains the following information:

1. The specific reasons for the denial, in language that is easy to understand.
2. A reference to the benefit provision guideline, protocol, or similar criterion on which the denial decision is based.
3. A statement the members can obtain a copy of the actual benefit provision, guideline, protocol, or similar criterion on which the denial was based, upon request.

Optum Rx also provides written notification of pharmacy denials to members and their treating providers regarding appeals rights and the appeal process. The documentation includes the following information:

1. A description of appeal rights, including the member's right to submit written comments, documents, or other information relevant to the appeal.
2. An explanation of the appeal process, including the appeal time frames and the member's right to representation.
3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials.
4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

Care Management Services

Program Goals and Scope

The Care Management program provides goal-oriented, individualized, systematic support through ongoing assessment, planning, advocacy, monitoring activities, coordination, and linkage with other health care providers and community resources. The services and activities of the Care Management program are reviewed, monitored, and documented to reflect progress toward individualized goals.

The goal of the program is to assist members who need added support services to optimize their health care outcome. This is accomplished through coordination of their benefit and health care needs while assisting them to navigate the health care system. The Care Management program aims to ensure that the member achieves the highest level of functioning in the least restrictive setting possible by facilitating the use of available benefits and resources. Support is given to the member to achieve self-stated goals for independence and reviewed in collaboration with the Primary Care Provider (PCP).

Care Management: UM Identification

Members needing Care Management or disease management services are identified on an ongoing basis through a variety of sources including inpatient and outpatient utilization/notification. UM refer members who appear to need additional support to Care Management team for assessment of eligibility for care management services, stratification, and member engagement.

CSH strives to support members throughout the continuum of care and achieve improved outcomes. Full Care Management program details can be found in the Care Management program description.

Appendix A. Delegation of UM Functions

Delegate	Delegated Preservice Function.
EyeQuest	Delegation of UM functions in administering non-medical vision care benefits.
DentaQuest	Delegation of UM functions in administering non-medical dental care benefits.
Optum Rx	Delegation of UM functions in administering pharmacy benefits.