



CLEAR SPRING
Health

2019 Provider Manual



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TABLE OF CONTENTS

Contents

TABLE OF CONTENTS	3
QUICK REFERENCE	7
Important Phone Numbers	7
Important Addresses.....	9
INTRODUCTION	10
About This Manual	10
CORPORATE OVERVIEW	10
OUR PLANS	10
Plan Types	10
Plan Co-Payments	11
BENEFITS	11
Summary of Benefits.....	11
PHARMACY BENEFITS	12
Formulary	13
Co-payments/Co-insurance	13
Drug Exclusions	13
Drugs Covered Under Part B.....	14
Drugs Covered Under Part B or Part D.....	14
Home Infusion.....	14
Vaccines	14
ENROLLMENT	14
DISENROLLMENT	14
MEMBER ID CARDS	15
PROVIDER RESPONSIBILITIES	16
Clear Spring Health Provider Network.....	16
TITLE VI of the Civil Rights Act of 1964	16
Coverage Arrangements	16
Appointment Standards.....	16
Office Hours	17
Provider Information Changes.....	17
Patient Safety	17

Closing Your Practice/Panel	18
Member Confidentiality.....	18
Verifying Member Eligibility.....	19
Advance Directives.....	19
Transfer of Non-Compliant Members.....	20
Fraud, Waste and Abuse	20
Access and Interpreters for Members with Disabilities.....	21
Encounters	22
Accurate Submission of Encounter Data	22
Provider Training.....	23
Contracts/No Gag Clause	23
Beneficiary financial protections	23
Health Care Disparities.....	24
QUALITY IMPROVEMENT.....	24
Goal: Quality Improvement Program	24
Objectives: Quality Improvement Program	25
Scope: Quality Improvement	25
UTILIZATION MANAGEMENT.....	26
Utilization Management Program	26
Goals and Objectives: Utilization Management Program	26
CDC Guideline for Prescribing Opioids for Chronic Pain.....	27
MEDICAL RECORDS.....	28
Medical Records Reviews.....	30
PROVIDER PERFORMANCE MEASURES	31
COORDINATION OF CARE.....	33
Member Outreach	33
Concurrent Review.....	33
Discharge Planning.....	34
HEALTH SERVICES	34
Service Authorization Requests	34
Inpatient Hospital Services Authorizations.....	36
Medicare Outpatient Observation Notice (MOON).....	36
Penalties for Not Obtaining Approval for Requested Services	36

Out of Network Authorization Requests	37
Second Opinions	37
Emergency Care and Services (ER).....	37
Service Denials	38
Self-Referrals.....	38
PREVENTIVE CARE GUIDELINES	38
NEW TECHNOLOGY	41
POLICIES AND PROCEDURES	42
Policy Changes.....	42
Practitioner Education and Sanctioning	42
CMS GUIDANCE ON MEDICARE MARKETING ACTIVITIES	42
Plans/Part D Sponsors may not allow contracted providers to:.....	43
Plans/Part D Sponsors may allow contracted providers to:	43
CLAIMS AND BILLING	43
Claims General Information	43
Timely Filing	44
Electronic Claims Submission.....	44
Requirements for Submitting Claims to Clear Spring through Change Healthcare.....	45
HIPAA 5010	45
Electronic Remittance Advice/Electronic Funds Transfer.....	46
Claims Review Process	46
Administrative Claims Review.....	47
Coordination of Benefits	47
BILLING.....	48
Billing Procedures	48
Hospital Services	50
UB-04 Data Elements for Submission of Paper Claim Forms.....	50
CMS-1500 (08-05) Data Elements for Submission of Paper Claim Forms	53
APPEALS AND GRIEVANCES.....	55
How to File a Grievance	56
Who May File a Grievance	57
When to File a Grievance	57
Timeframes for Resolution	57
Expedited Grievances.....	57

Quality Improvement Organization Review (QIO).....	58
How to File a Quality of Care Complaint with the QIO	58
Appeals.....	58
Who May Request a Reconsideration?.....	59
How to Request a Standard Reconsideration	59
How to Request an Expedited Reconsideration	59
Reconsideration Filing Timeframes	59
Reconsideration Decision Timeframes	60
Regarding Hospital Discharge	60
Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) Services	61
Quality Improvement Organization (QIO) Review.....	61
IRE Review.....	62
Administrative Law Judge Review.....	62
Medicare Appeals Council.....	62
Federal Court.....	63
Acting as an Authorized Representative.....	63
INTRODUCTION TO CREDENTIALING	63
Purpose of Credentialing	64
Credentialing Standards.....	64
Ongoing and Performance Monitoring.....	65
Practitioner Absences	66
Denial and Termination	66
Delegated Credentialing	67

QUICK REFERENCE

Important Phone Numbers

Call to Inquire About:	Telephone Number
Provider Services (Benefit & Claim Inquiries, Eligibility Verification)	877-384-1241
Vision – Provider Services	833-825-3415
Dental – Provider Services	833-825-3415
Hotline to report Fraud and Abuse or Compliance Concerns	866-467-6958
Hearing Care– Provider Services	877-583-2842
Utilization Medical & Behavioral Health Management	866-689-8761
*Inpatient UM Fax/email	*866-611-1957 inpatientutilization@eonhp.com
*Outpatient UM Fax/email	*866-613-0157 outpatientutilization@eonhp.com
Member Services	877-384-1241
Pharmacy - IL	833-478-6372
Pharmacy - CO, NC, VA	833-459-4421
Care Management	866-391-6511
Part D Prescriber Appeals	877-384-1241
TTY/TDD (for all departments)	711
Fitness Program	877-427-4788
Over The Counter Program (OTC)	888-246-6001

Important Addresses

Reason for Mailing	Address
Claims (Medical & Behavioral Health)	Clear Spring Health Attn: Claims P.O. Box 4048 Scranton, PA 18505
Claims Inquiries and Administrative Review	Clear Spring Health Attn: Claims P.O. Box 4048 Scranton, PA 18505-9875
Practice Change Information	Clear Spring Health Attention: Provider Relations & Recruitment 3620 Enterprise Way Miramar, FL 33025
Provider Appeals	Clear Spring Health Appeals and Grievances P.O. Box 4048 Scranton, PA 18505-9875

INTRODUCTION

About This Manual

Clear Spring Health's Provider Relations, Provider Services, Member Services, and Member Outreach staff, among others, is committed to providing accurate, up-to-date, and comprehensive information to our member and practitioner populations through prompt and dedicated service. Understanding Clear Spring Health's policies and procedures is essential. The Provider Manual is one way of providing participating practitioner offices, hospitals and ancillary providers with information regarding Clear Spring Health's policies and procedures and is considered part of your contractual agreement with the health plan. Consider this manual a general guideline for Clear Spring's provider network. The manual is a ready reference and is updated, as needed. Please retain all updates with your manual.

This Manual and any updates are available on our website under the Providers section:
www.ClearSpringHealthCare.com.

CORPORATE OVERVIEW

Clear Spring Health is a subsidiary of **Delaware Life Insurance Company** and its parent, **Group One Thousand One LLC**. Delaware Life (DelawareLife.com) has 40 years of insurance experience, has earned an A- (Excellent) rating from A.M. Best.

Group One Thousand One (Group1001.com) is on a mission to make insurance more useful, intuitive and accessible to everyone, developing user-centric insurance solutions that can make a real-life difference in people's lives.

As a result, Clear Spring Health is dedicated to making Medicare-Advantage plans simpler, smarter and packed with value for Medicare beneficiaries, while operating from a foundation of integrity, successful leadership and rock-solid financial strength.

OUR PLANS

Plan Types

Clear Spring Health offers two Medicare Advantage Part D (MAPD) plans serving those who have both Medicare Parts A and B and live within the county service areas:

- 1) (HMO) - Illinois Service Area: Boone, Clinton, Cook, DuPage, Kane, Kankakee, LaSalle, Macoupin, Madison, McHenry, Ogle, St. Clair, Stephenson, Will, Winnebago
- 2) (PPO) - Colorado Service Area: Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer, Weld
 - North Carolina Service Area: Robeson, Scotland
 - Virginia Service Area: Chesterfield, Colonial Heights, Hanover, Henrico, Hopewell City, Petersburg City, Richmond City

Plan Co-Payments

A member's out of pocket expense or cost sharing will vary depending upon the level of assistance they may be receiving from the State, Medicare, as well as which Clear Spring Health plan they have chosen to join. For more benefit information, see the Summary of Benefits.

BENEFITS

Medical Benefits

Clear Spring Health members are eligible for all the benefits covered under the Original (Fee-for-service) Medicare Program. In addition, Clear Spring Health offers additional benefits for pharmacy, dental, vision, hearing and health and wellness services (plan benefits vary by plan). For a complete list of covered benefits, please refer to the Evidence of Coverage. A complete copy of the Evidence of Coverage booklet for each health plan option is located on our website at www.ClearSpringHealthCare.com. Members obtain most of their healthcare services either directly from their primary care practitioner or upon referral by an in-network specialist/ ancillary provider; except for services available on a self-referral basis, such as OB/GYN services and routine vision services. The primary care practitioner is responsible for the coordination of a member's healthcare needs and access to services provided by hospitals, specialty care practitioners, ancillary providers, and other healthcare providers as needed.

Clear Spring Health offers the following benefits to enrolled members (benefits vary based on service area):

- 1) All the benefits of original Medicare and more
- 2) Prescription drug coverage*
- 3) Hearing, vision, and dental benefits *
- 4) Fitness program to help members stay fit
- 5) Over the Counter (OTC)
- 6) Lower copayments and deductibles on select plans
- 7) No referrals for in-network providers

*Benefit coverage varies by product.

Summary of Benefits

The covered services listed in the Summary of Benefits are covered only when all requirements listed below are met:

- Services must be provided according to the Original Medicare coverage
- Guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Medically necessary refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the member's doctor. Certain preventive care and screening tests are also covered.

- With few exceptions, covered services must be provided by plan providers, be approved in advance by plan providers, and some services may need to be authorized by our Plan.
- For those temporarily out of the service area emergency and urgently needed services will be covered as provided in 42 CFR 422.113

In addition, some covered services require “prior authorization” by the Plan to be covered. Some of the covered services listed in the Summary of Benefits attachments are covered only if the member’s doctor or other plan provider gets “prior authorization” (approval in advance) from our Plan. Covered services that may need prior authorization (approval ahead of time) are marked in the Summary of Benefits as “Authorization rules may apply”.

The Summary of Benefits can be found on Clear Spring Health’s website, www.ClearSpringHealthCare.com

General Exclusions

Exclusions or limitations are described in the Evidence of Coverage (EOC) booklet. The Evidence of Coverage booklet can be found on Clear Spring Health’s website at www.ClearSpringHealthCare.com

At any time during the year, the Medicare program can change its national coverage. Since Clear Spring Health covers what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease benefits, depending on the Medicare program changes.

PHARMACY BENEFITS

Prescription drug benefits are available to all Clear Spring Health members. Prescriptions must be filled by a participating pharmacy to be covered. When a member travels outside of the plan service area a national network of pharmacies is available via the Envision RX network. If a member must use an out-of-network pharmacy, the member will generally have to pay the full cost of the prescription. The member may then request to be reimbursed for the cost covered by Clear Spring.

Clear Spring contracts with Envision RX to develop a network of chain, independent, home infusion and long-term care pharmacies in order to provide pharmaceuticals to Clear Spring Health members. A list of participating pharmacies can be obtained by looking on our website on www.ClearSpringHealthCare.com or contacting Clear Spring’s Member Services Department at:

- 877-384-1241
- TTY: 711

Prescriptions are available to members who are eligible for pharmacy coverage when written by an Clear Spring practitioner. Prescription coverage and cost varies by plan.

Formulary

Clear Spring offers an extensive drug formulary. Generic prescriptions, when appropriate, are the most cost effective alternatives. Clear Spring's formulary includes a complete list of the drugs that we cover, generic and brand name and any requirements, limits and/or restrictions for each drug, if applicable. Visit www.ClearSpringHealthCare.com for the most recent version of the formulary. Pharmacy cost information is also noted in the Evidence of Coverage booklet.

Co-payments/Co-insurance

Member cost sharing for medications varies by plan, drug type and the amount of extra help, if any, that the member may receive. Members should contact Clear Spring Member Services to learn more about their specific coverage.

Please Note: The Plan may place limits on the amount of medication a member may receive. Members can receive up to a 31-day supply of medication for prescriptions filled at an in-network pharmacy or up to a 90-day supply of medication for prescriptions filled at an in-network 90-day retail pharmacy. A 90-day mail order benefit is available for select plans.

Some formulary medications may have additional requirements or limits on coverage. These requirements and limits may include: prior authorization, quantity limits, or step therapy. If use of a formulary medication is not medically advisable for a member, you must complete a Drug Exception Form. Please refer to the Forms and Reference Materials Section of this manual for a copy of this form. Please refer to the Referral and Authorization Section of this manual for information regarding requesting non-formulary drugs. The Drug Exception Form can also be found on Clear Spring Health's website.

Drug Exclusions

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If one of these reference books, known as compendia, does not support the use then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Drugs Covered Under Part B

Drugs covered under Part B are typically administered and obtained at the provider's office. Some examples are certain cancer drugs, administered by a provider in his/her office; insulin when administered via pump and diabetes test strips.

Drugs Covered Under Part B or Part D

Some drugs can fall under either Part B or Part D. The determination of coverage as to whether the drug is Part B or Part D is based on several factors such as diagnosis, route of administration and method of administration. For a list of medications in this category, refer to the CMS website at www.cms.gov; choose **Medicare -> Prescription Drug Coverage-General Information -> Downloads**, and select the appropriate document. Alternatively, you may contact our Pharmacy department.

Home Infusion

Clear Spring Health will cover drugs for home infusion therapy if the home infusion services are provided by a home infusion therapy network pharmacy. However, Medicare part D does not cover the supplies and equipment needed for administration. For information on home infusion therapy, contact our Pharmacy department.

Vaccines

Most vaccines and the administration fees are covered under Part D. Clear Spring Health provides coverage of a number of vaccines, some of which are considered to be medical benefits (Part B medications) and other which are considered to be Part D drugs. If you are unsure of how a vaccine will be covered by Clear Spring Health, refer to the Formulary which is available on our website, www.ClearSpringHealthCare.com

Part D covers most preventative vaccines; Part B covers flu, pneumococcal, hepatitis B and some other vaccines (i.e. rabies) for intermediate or high-risk individuals when directly related to the treatment of an injury or direct exposure to a disease or condition.

ENROLLMENT

The Centers for Medicare and Medicaid Services (CMS) has periods when beneficiaries can enroll or disenroll with/from Medicare. These times are known as election periods. Members can enroll into our plan by using any of these methods:

- Mailing in a paper enrollment form
- Enrolling on-line through Medicare's website
- Enrolling on-line through www.clearspringhealthcare.com
- By calling Clear Spring Health at 877-384-1241 (TTY users should call 711)

DISENROLLMENT

A **voluntary** disenrollment may occur as a result of a written request by the member.

An **involuntary** disenrollment may occur as a result of, including but not limited to, one of the following:

- If the member does not stay continuously enrolled in both Medicare Part A and Medicare Part B.
- If the member gives false or deliberately misleading information on the enrollment application having an impact on whether they qualify or not.
- If member behaves in a way that is unruly, uncooperative, disruptive or abusive and his/her behavior seriously affects your ability to arrange or provide medical services, you must notify Clear Spring Health. Before Clear Spring takes makes a determination to disenroll the member for this reason, Clear Spring must obtain permission from the Center for Medicare and Medicaid Services (CMS).
- If the member allows someone else to use his/her member ID card in order to obtain medical care. Before disenrolling the member, for this reason, Clear Spring must refer the case to the Office of the Inspector General and this may result in criminal prosecution of the member and the person(s) seeking care.

MEMBER ID CARDS

Each Clear Spring Health member will receive an ID card. Each card is issued once, unless cards are requested or reissued due to a demographic, PCP or plan change. ID Cards are good for as long as the person is a member of Clear Spring Health.

(Sample ID Cards) **HMO**



PPO



Member Services:	1-877-384-1241
TTY:	711
Pharmacy Services:	1-833-478-6372
Dental Services:	1-833-825-3415
Hearing Services:	SAMPLE 1-866-344-7756
Vision Services:	1-833-825-3415
Behavioral Health Services:	1-877-384-1241
Provider Services:	1-877-384-1241
Utilization Review/Inpatient Services:	1-866-689-8761
Paper Claims	Electronic Claims
Clear Spring Health	Payor ID: 66009
Attention: Claims	
P.O. Box 4048	
Scranton, PA	
18505	www.ClearSpringHealthCare.com

Member Services:	1-877-384-1241
TTY:	711
Pharmacy Services:	SAMPLE 1-833-459-4421
Vision Services:	1-833-825-3415
Behavioral Health Services:	1-877-384-1241
Provider Services:	1-877-384-1241
Utilization Review/Inpatient Services:	1-866-689-8761
Paper Claims	Electronic Claims
Clear Spring Health	Payor ID: 66009
Attention: Claims	
P.O. Box 4048	
Scranton, PA	
18505	www.ClearSpringHealthCare.com

PROVIDER RESPONSIBILITIES

Clear Spring Health Provider Network

Clear Spring Health contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. Clear Spring Health has an extensive network of pharmacies to service members across our service areas. Practitioners and other healthcare providers are chosen in such a manner that existing patterns of care, including patterns of hospital admissions, can be maintained. Participation in Clear Spring Health in no way precludes participation in any other program with which the provider may be affiliated. To find a provider go to www.ClearSpringHealthCare.com to access Clear Spring's On-Line Provider Directory.

The following requirements are the basic guidelines to which you, as a provider, have agreed in your Provider Agreement with Clear Spring Health. These requirements are organized into responsibilities for all providers, for primary care physicians, for specialist and for physician extenders. You will be updated, as necessary, with any regulatory changes that require revisions to standard responsibilities.

TITLE VI of the Civil Rights Act of 1964

Providers are expected to comply with the Civil Rights Act of 1964. Title V of the Act pertains to discrimination on the basis of national origin or limited English proficiency. Providers are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of translator services as necessary for these members.

Coverage Arrangements

All participating practitioners must ensure 24-hour, 7 days-a-week coverage for members. Coverage arrangements should be made with another Clear Spring participating practitioner or practitioners who have otherwise been approved by Clear Spring. All encounters must be billed under the name of the rendering practitioner, not the member's assigned primary care practitioner. Reimbursement will be paid directly to the participating covering primary care practitioner.

Covering practitioners, whether participating or not, must adhere to all of Clear Spring's administrative requirements. Additionally, covering practitioners must agree not to bill the member for any covered services. The covering practitioner should report all calls and services provided to the member's primary care practitioner. Participating practitioners will be held responsible for the actions of their non-participating coverage practitioners. Participating practitioners will not use any practitioner who is excluded for the Medicare program for coverage in their absence.

Primary care practitioners agree that, in their absence, timely scheduling of appointments for members shall be maintained.

Appointment Standards

Primary care practitioners agree to meet Clear Spring Health's appointment standards, as follows:

REQUIREMENT	STANDARD
Wait time for Emergent Appointment	Immediately seen, or instructed to call 911 or go directly to the nearest emergency room.
Wait time for Urgent Care Appointment	Within 24 hours
Wait time for Non-Urgent Sick Visit	Within 1 week
Wait time for Routine, Wellness Appointment	Within 30 days (4 weeks)
After Hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week, 365 days a year
Waiting Time in the Waiting Room	No more than thirty (30) minutes or up to one (1) hour when the MD encounters an unanticipated Urgent Medical Condition visit or is treating a member with a difficult need.

* A member should be seen by a practitioner as expeditiously as the member's condition warrants, based on the severity of symptoms. If a practitioner is unable to see the member within the appropriate timeframe, Clear Spring Health will facilitate an appointment with a participating or non-participating practitioner, if necessary.

Office Hours

Office hours for all physicians should be posted and should be reasonable. Hours of operations must be convenient and not discriminate against Clear Spring members relative to:

- Other, non-Medicare members
- Members who require access to care after normal business hours (5p.m – 9a.m.) for urgent medical events that require attention after hours.
- Members who are not able to take time off from work to receive their care (Medicare Working-Aged).

Provider Information Changes

The Clear Spring Health physician agreement indicates participating providers must submit written notice ninety (90) calendar days prior to the date the provider intends to terminate. There is also sixty (60) days notice required if you plan to close your practice to new patients and thirty (30) days notice required for a practice location change. All changes must be submitted in writing to Clear Spring Health on provider letterhead.

Patient Safety

Patient safety is the responsibility of every healthcare professional. Health care errors can occur at any point in the health care delivery system and can be costly in terms of human life, function, and health care dollars. There is also a price in terms of lost trust and dissatisfaction experienced by both patients and health care practitioners.

Providers are required to meet safety standards in accordance with the Occupational Safety and Health Administration (OSHA), Americans Disability Act (ADA), Rehabilitation Act, and other federal/state regulatory requirements. This includes ensuring equipment, lab, office, restrooms, waiting area chairs and table, examination room and equipment are in good working order.

Providers will establish a plan in compliance with OSHA standards regarding blood borne pathogens. In addition, provider will make the necessary provisions to minimize sources and transmission of infection in the office.

Closing Your Practice/Panel

As an Clear Spring participating provider, you are required to provide Clear Spring prior written notice of no less than 60 calendar days if you are closing your practice. Providers are permitted to limit the number of new patients they accept, subject to the terms of their agreement with Clear Spring. Please note that a panel must be closed to all new patient and not only to Clear Spring members.

Member Confidentiality

Through contractual agreements, all practitioners and providers participating with Clear Spring Health have agreed to abide by all policies and procedures regarding member confidentiality.

Under these policies, the practitioner or provider must meet the following:

1. Provide the highest level of protection and confidentiality of members' medical and personal information used for any purposes in accordance with federal and state laws or regulations including, but not limited to the following:
 - Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164
 - The Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub.L.No. 111-5 (Feb 17, 2009) and related regulations
 - The HIPAA Omnibus Rule, effective 3-26-2013 with a compliance date of 9-23-2013.
2. Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.
3. Assure that a member's individually identifiable health information as defined by HIPAA, also known as Protected Health Information (PHI), necessary for treatment, payment or healthcare operations (TPO) is released to Clear Spring Health without seeking the consent of a member. This information includes PHI used for claims payment, continuity and coordination of care, medical record audits, treatment, health assessments, performance measures (i.e. HEDIS), quality of care issues, and care and/or disease management.
4. All staff discussions related to confidential member information should be conducted in a private area, away from treatment or waiting areas.
5. Employees should have instructions on confidentiality policy and awareness training on their legal obligations regarding confidentiality.
6. Members must be informed of your confidentiality policy and privacy practices and may sign a document to that affect.

Clear Spring Health follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the payment, treatment or operational function.

Verifying Member Eligibility

The presentation of a member's ID card neither creates nor serves to verify a member's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. Providers are required to take the following steps prior to administering services:

1. Verify member's eligibility with Clear Spring Health. Members are eligible if:
 - a. Is currently enrolled
 - b. Is eligible for the requested services
 - c. Has not exhausted his or her benefits
 - d. Did not disenroll after receiving the membership card
2. Check the authenticity of the member's ID card to avoid problems with identity theft or fraud. Be sure to ask the member for an additional form of identification such as a driver's license.
3. Make a copy of the member's ID card and make it part of the member's medical record.

All providers are responsible for the verification of member eligibility prior to rendering services to ensure reimbursement. Provider can verify eligibility through the provider portal at www.ClearSpringHealthCare.com or eligibility verification line can be reached at 877-384-1241, from October 1 – March 31, seven days a week, from 8:00 a.m. – 8:00 p.m. and from April 1 – September 30, Monday through Friday, 8:00 a.m. – 8:00 p.m.

Providers can also submit an electronic 270 Health Care Eligibility/Benefit Inquiry transaction to Change Healthcare to request information about the member's coverage. Change Healthcare will return a 271 Health Care Eligibility/Benefit Response transaction

Advance Directives

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a law that has come to be known as the Patient Self-Determination Act. It became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home health care or personal care services, hospice programs and health maintenance organizations that receive Medicare or Medicaid funds. The primary purpose of the act is to make sure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute an advance directive if they so desire. The Act also prevents discrimination in health care if the member chooses not to execute an advance directive.

As a participating provider within the Clear Spring Health network, you are responsible for determining if the member has executed an advance directive and for providing education about advance directives when it is requested. A copy of the "Living Will" form should be maintained in the member's medical record. Clear Spring's Medical Record Review Standards state that providers should ask members age 21 and older whether they have executed an advance directive and document the member's response

in their medical records. If a member has executed an advanced directive, it will be placed in the medical record in an area that is clearly marked "Advanced Directives".

Providers will receive educational materials regarding a member's right to advance directives upon entering the Clear Spring Health practitioner network.

Transfer of Non-Compliant Members

Primary care practitioners agree (a) not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Clear Spring Health members on the basis of race, sex, age, religion, place of residence, health status or source of payment; and (b) to observe, protect and promote the rights of members as patients. Primary care practitioners shall not seek to transfer a member from his/her practice based on the member's health status. However, a member whose behavior would preclude delivery of optimum medical care may be transferred from the practitioner's panel. Clear Spring Health's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given practitioner.

Should an incidence of inappropriate behavior occur and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel including the member's name, Clear Spring Health ID Number, and details of the non-compliant behavior to the Medicare Enrollment Department at:

**Clear Spring Health
Attention: Medicare Enrollment
3620 Enterprise Way
Miramar, FL 33025
Or FAX 1-866-235-5181**

The Enrollment Department notifies the requesting practitioner in writing when the transfer has been accomplished. If the member requests not to be transferred, the primary care practitioner is responsible for continuation of care for at minimum 30 days until the member is assigned to a new primary care physician.

Primary care practitioners are required to provide emergency care for any Clear Spring Health member dismissed from their practice until the member transfer has been completed.

Fraud, Waste and Abuse

Clear Spring Health has a comprehensive policy for handling the prevention, detection and reporting of fraud and abuse. Clear Spring Health's policy to investigate any actions by members, employees or practitioners affects the integrity of Clear Spring Health and or the Medicare Program.

As a participating practitioner with Clear Spring Health requires compliance with Clear Spring Health's policies and procedures for the detection and prevention of fraud and abuse. Such compliance may include referral of information regarding suspected or confirmed fraud or abuse to Clear Spring and submission of statistical and narrative reports regarding fraud and abuse detection activities.

If fraud or abuse is suspected, whether it is by a member, employee or practitioner, it is your responsibility to immediately notify Clear Spring Health at 866-467-6958.

All practitioners and providers participating with Clear Spring Health agree to abide Clear Spring Health's Fraud, Waste, and Abuse and Reporting policy, which can be accessed on Clear Spring Health's website at www.ClearSpringHealthCare.com. This policy and procedure include legal requirements determined by the state as determined by the plan's coverage area:

- 31 U.S.C. §3729 of the Federal False Claims Act
- SEC. 1128. [42 U.S.C. 1320a-7]
- 31 U.S.C. 3729 False Claims Act Sanctions
- TITLE 18--CRIMES AND CRIMINAL PROCEDURE

Providers are requested to review the Fraud, Waste and Abuse and Reporting policy on Clear Spring Health's website periodically to determine if any changes have occurred.

It is Clear Spring Health's policy to discharge any employee, terminate any provider or recommend any member be withdrawn from the Medicare Program who, upon investigation, has been identified or has been involved in fraudulent or abusive activities. Some common examples of fraud, waste and abuse are:

- Billing for services not rendered
- Billing for supplies not being purchased or used
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand name drugs
- Falsifying records
- Performing inappropriate or unnecessary services

Access and Interpreters for Members with Disabilities

Providers are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each provider is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. Clear Spring Health will assist providers in locating resources upon request. Clear Spring Health offers the Member Handbook and other Clear Spring Health information in large print, Braille, on cassette tape, or computer diskette at no cost to the member. Please instruct members to call Member Services at 877-384-1241(TTY 711).

Practitioner offices are required to adhere to the Americans with Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting Clear Spring Health's Provider Services Department at 877-384-1241. For interpreter services, please contact Clear Spring Health's Member Services at 877-384-1241 to arrange and coordinate interpreter services.

Encounters

Primary care practitioners are required to report to Clear Spring all services they provide for Clear Spring members by submitting complete and accurate claims. All Clear Spring providers are contractually required to submit encounters for all member visits and all charted diagnoses that the member may suffer from.

Accurate Submission of Encounter Data

Encounter data provides the basis for many key medical management and financial activities at Clear Spring:

- Healthcare assessments and studies;
- Access and availability of service evaluation;
- Program identification and evaluation;
- Utilization pattern evaluation;
- Operational policy development and evaluation, and;
- Financial analysis and projection.

To effectively and efficiently manage member's health services, encounter submissions must be comprehensive and accurately coded. All Clear Spring providers are contractually required to submit encounters for all member visits. Underreporting of encounters can negatively affect all stakeholders.

For primary care practitioners, encounter data is essential as many of Clear Spring's quality indicators are based on this information. Clear Spring evaluates primary care practitioner encounter data in two ways. The rate of submitted encounters, per member for individual primary care practitioner practices is measured and compared to a peer average based on specialty (i.e. Family Medicine, Internal Medicine). Additionally, Clear Spring extracts dates of service during on-site medical record review and compares the visit dates to encounters submitted to the health plan. This rate is also compared to peer averages.

It is very important that all diagnosis codes that are applicable to the member be submitted on every claim, especially chronic conditions. The expected rate of submission for encounters is 100%. Clear Spring provides support and education to practices as indicated by their encounter submission rates.

CMS uses the Hierarchical Condition Categories (HCC) model to assign a risk score to each Medicare beneficiary. Accurate and complete reporting of diagnosis codes on encounters is essential to the HCC model. Physicians must establish the diagnosis in the medical record and coders must use the ICD-10-CM coding rules to record each diagnosis. Chronic illnesses should be coded on each encounter along with the presenting illness. This will help to ensure that CMS has complete data when determining the member's risk score.

There are two volumes, which consist of:

The Disease Tabular (Numeric) and is known as Volume I of ICD-10-CM. Numeric listing of codes organized by body system. This volume provides more detail than the Alphabetic Index on conditions included and excluded in the code selected. Another code in the same category may represent the diagnostic description better than the one indicated in the Disease Index.

The Disease Index (Alphabetic) and is known as Volume II of ICD-10-CM. This volume is an index of all diseases and injuries categorized in ICD-10-CM. When a code is listed after the description, it means the reader should look up that code in the Disease Tabular section to determine if that is the most specific code to describe the diagnosis. The index is organized by main terms and sub terms that further describes or specifies the main term. In general, the main term is the condition, disease, symptom, or eponym (disease named after a person), not the organ or body system involved.

Provider Training

We are aware that, to provide exceptional access and quality health care to our members, it is essential that our providers and their staff have a solid understanding of the member's needs, our contract requirements and other protocols, as well as applicable contract standards and Federal and/or State regulations.

Within 30-90 calendar days of successful completion of provider credentialing and approval to participate in our network our Provider Relations Department provides introductory training to providers and their office staff. The Provider Manual is reviewed at orientation and placed on Clear Spring Health's website, www.ClearSpringHealthCare.com. This provider training familiarizes new providers and their staff with Clear Spring Health's policies and procedures.

Each participating primary care practice, specialty care practice and hospital is assigned a Provider Relations Representative, who is responsible for ongoing education in their assigned Service Area. As a follow-up to the initial orientation session, the assigned Provider Relations Representative regularly contacts each provider and their staff to ensure that they fully understand the responsibilities outlined in the Provider Agreements and Manual.

Contracts/No Gag Clause

Clear Spring Health allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for the patient. All Clear Spring Health contracts with practitioners and providers include an affirmative statement indicating that the practitioner can freely communicate with patients regarding the treatment options available to them, including medication treatment options available to them, regardless of benefit coverage limitations. There is no language in Clear Spring Health's contracts that prohibits open clinical dialogue between practitioner and patients

Beneficiary financial protections

Clear Spring Health agrees to comply with the following requirements:

- Clear Spring Health will adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability (for example, as a result of an organization's insolvency or other financial difficulties) for payment of any fees that are the legal obligation of the Clear Spring Health. To meet this requirement, Clear Spring Health:
- Ensure that all contractual or other written arrangements with providers prohibit the organization's providers from holding any enrollee liable for payment of any such fees;

- Indemnify the enrollee for payment of any fees that are the legal obligation of Clear Spring Health or the state Medicaid Program (dual eligible members). Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will accept Clear Spring Health's payment as payment in full, or bill the appropriate State source.

Health Care Disparities

Clear Spring understands that to help improve our members' quality of life, we must take into account their cultural uniqueness. For this reason, addressing disparities in health care is high on our leadership's agenda. We believe a strong patient-provider relationship is the key to reducing the gap in unequal health care access and health care outcomes due to cultural and language barriers. Clear Spring is continuously working to close the gap in health outcomes by focusing on education and prevention.

Providers must deliver services and information regarding treatment options in a language the member understands, and in a culturally competent manner, accommodating the special needs of ethnic, cultural and the social circumstances of the patient.

QUALITY IMPROVEMENT

Purpose: Quality Improvement Program

The purpose of the Quality Improvement Program is to provide a formal process by which the quality, appropriateness, efficiency, safety and effectiveness of care and services are objectively and systematically monitored and evaluated.

This process allows the Plan to identify operational areas for improvement, effectiveness of care and services in relation to enrollee health outcomes, as well as, enrollee and provider satisfaction. The Quality Improvement Program promotes the accountability of all employees and affiliated health personnel for the quality of care and services provided to enrollees.

As a participating provider, Clear Spring Health asks that you cooperate with QI activities to improve the quality of care and services members receive. This may include the collection and evaluation of data, participation in various QI initiatives and programs and allowing the plan to use and share your performance data.

Goal: Quality Improvement Program

The goal of the QI Program is to ensure the provision and delivery of high quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality services. The QI Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Clear Spring Health care provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement concepts and appropriately recognized quality measurement tools and reports, such as qualitative, quantitative and root/cause barrier analyses, Clear Spring Health focuses on assessing its performance outcomes to

identify opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services, and achieving positive member health outcomes.

Objectives: Quality Improvement Program

The objectives of the QI Program are consistent with Clear Spring Health's mission, commitment to effective use of healthcare resources, to achieve program goals for continuous quality improvement. The program goals are documented in the annual QI Program Description. The QI Program is assessed on an annual basis to determine the status of all activities and identify opportunities that meet the QI Program objectives.

Objectives are as follows:

- Improvement of the enrollees' health status and outcomes by incorporating health promotion programs and enforcing preventive medicine;
- Identification and increase awareness of appropriate and safe delivery systems by monitoring and evaluating health care delivery and services;
- Evaluate the standards and appropriateness of clinical care and performance, and promote the most effective use of resource while maintaining coordination and continuity of health care and services;
- Evaluation of access and availability of care and services;
- Oversight and improvement of member and provider satisfaction;
- Monitor over and under-utilization of services;

Scope: Quality Improvement

The QI Program uses appropriate internal information systems, practitioners, and community resources to monitor and evaluate use of healthcare services, the continuous improvement process and to assure implementation of care intervention strategies.

The scope of the Program includes:

- Members' Rights and Responsibilities
- Network Accessibility and Availability, including those related to Special Needs
- Healthcare Disparities
- Network Credentialing/Re-credentialing
- Medical Record Standards
- Member and Provider Services
- Preventive Health
- Clinical Outcomes
- Oversight of Delegated Activities
- Member Safety
- Quality of Care
- Model of Care
- Continuous Quality Improvement

To request a copy of the Quality Improvement Program, Work Plan or Annual Evaluation please contact Clear Spring's Provider Relations Department at 1-866-788-3640.

UTILIZATION MANAGEMENT

Utilization Management Program

The Utilization Management (UM) Program is a component of the Health Services Department and monitors both access and quality of care using nationally recognized, evidence-based standards of care across the Medicare lines of business. The UM program facilitates optimal settings for delivery of care and educates physicians and facilities on the advantages of managing care in a medically appropriate and cost-effective manner. The UM structure is routinely evaluated such that appropriate utilization is continuously monitored and corresponding interventions initiated to improve health outcomes. The UM program maintains regulatory compliance and is annually reviewed by the Clear Spring Health's Utilization Management Committee (UMC) and annually approved by the Quality Improvement Committee (QIC).

The UM Program and QIC work together to evaluate the care and service provided to members, identify opportunities for improvement, prioritize the improvement opportunities and interventions, and assist in the re-measurement process to determine the effectiveness of the interventions provided.

Goals and Objectives: Utilization Management Program

The UM program is designed to accomplish the following objectives:

- Demonstrate flexibility in the application of members' benefits to ensure that all medically necessary services are available to members;
- Collaborate with and provide necessary oversight to delegated entities to ensure a high quality of care for members;
- Develop, implement and maintain an ongoing process aimed at assuring proper utilization of health care resources within the established benefit plan;
- Educate clinical and support staff on the purpose and philosophy of the UM program;
- Assure that members receive the highest quality of medically necessary care delivered in the most appropriate setting;
- Evaluate and determine benefit exception authorizations based on explicit outcome expectation, related to unique, individual needs of each member;
- Providing individualized and integrated care to each member;
- Maintain the rights and responsibilities of the member during all aspects of review;
- Review and analyze UM data and statistics to identify trends and opportunities for improvement;
- Work collaboratively and cooperatively with the Quality Improvement department;
- Review, update as necessary, approve and implement the UM program and all related processes, policies, and procedures at least annually;
- Comply with professional standards, guidelines and criteria set by governmental and other regulatory agencies;
- Improve coordination of care between Primary, Specialty and Behavioral Health disciplines;

- Optimize healthcare utilization by assisting provider with tool, resources, and information to better manage the members;
- Maintain and monitor the provider network in order to provide adequate access to covered services and to meet the needs of the member population served;
- Partner with providers including local Public Health and Social Service agencies, to achieve optimum member outcomes; and
- Monitor overutilization, underutilization and inappropriate use of services through regular care plan and service utilization reviews;

CDC Guideline for Prescribing Opioids for Chronic Pain

The CDC developed and published the *CDC Guideline for Prescribing Opioids for Chronic Pain* to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

In order to be compliant with 42 CFR §423.153(b)(2), Clear Spring Health in partnership with its Pharmacy Benefit Manager EnvisionRx, steps are being taken to ensure prescribers understand the criteria used to identify potentially at-risk Medicare beneficiaries, specifically point-of-sale edits. EnvisionRx's clinical team will provide information ensure prescribers understand the reason for implementing edits. The point-of-sale edits will be administered by EnvisionRx:

- Seven-day supply limit for initial fills (opioid naïve) edit
 - Edit logic: Members considered to be opioid naïve (no history of opioid use in the past 120 days) will be limited to a seven-day supply or less of opioids for their initial fill.
 - Resolution for reject: Reduce day supply to seven days or less, pharmacy enter continuation of therapy override, member requests a coverage determination exception
- Care coordination edit (90 MME)
 - Edit logic: Members meeting or exceeding 90 MME will be required to have an additional check to ensure safety of utilizing ≥ 90 MME per day.
 - Resolution for reject: Dispensing overrides reject with codes once they have contacted the prescriber to validate safety or member requests a coverage determination exception if pharmacy is unable to resolve the edit at the point – of-sale.
- Duplicative long-acting (LA) opioid therapy edit
 - Edit logic: Members utilizing more than one extended release opioid concomitantly will require the dispensing pharmacy to ensure safety of the member's opioid regimen.
 - Resolution for reject: Dispensing pharmacy overrides reject with codes only if they have verified it is safe and appropriate for the member to utilize >1 extended release opioid.

- Concurrent opioid and benzodiazepine use edit
 - Edit logic: Members utilizing an opioid analgesic and benzodiazepine concomitantly will require the dispensing pharmacy to ensure safety of the member's regimen.
 - Resolution for reject: Dispensing pharmacy overrides reject with codes only if they have verified it is safe and appropriate for the member to utilize an opioid analgesic and benzodiazepine together.
- Concurrent opioid and buprenorphine use edit
 - Edit logic: Members utilizing opioid analgesics and buprenorphine medications only indicated for the treatment of opioid dependence concomitantly require an additional safety check to ensure it is appropriate to fill an opioid medication while a buprenorphine medication indicated only for the treatment of opioid dependence is still active.
 - Resolution for reject: Dispensing pharmacy overrides reject with codes only if they have verified it is safe and appropriate to utilize an opioid analgesic in conjunction with a buprenorphine medication that is only indicated for the treatment of opioid dependence.

MEDICAL RECORDS

Medical record documentation should facilitate communication, coordination and continuity of care and services, as well as, promote efficiency and effectiveness of treatment. Participating providers are required to keep accurate and complete medical records of Clear Spring Health's members for at a minimum of 10 years.

Medical Records Standards

Providers must ensure that their medical records meet Clear Spring's medical record standards. Medical record standards incorporate criteria from applicable federal, state and regulatory requirements.

The following are expanded descriptions of the requirements:

- a. **Patient Identifiers**: Patient name or unique identifier number should appear on each page of the medical record;
- b. **Biographical Information**: Each medical record should contain: Patient's name, date of birth, address, home and work phone numbers, marital status, sex, name of emergency contact and phone number, appropriate consent forms and guardianship information, if relevant;
- c. **Date and Signatures**: All entries on the medical record should be dated and signed/initialed by the author. Author identification includes name of the practitioner rendering services including signature or initials followed by the title (M.D., D.O., D.C., D.P.M., P.A., A.R.N.P., R.N., L.P.N., M.A., etc.); Stamp signatures will not be accepted; ARNPs and PA's documentation must be co-signed by the physician;

- d. Language:** Documentation of primary language spoken and any translation needs must be included as part of the medical record, documentation of any other needed communication assistance;
- e. Legibility:** All entries should be legible;
- f. Past Medical History:** There should be documentation within the medical record of past medical history obtained by the member's first visit, which should include significant surgeries, procedures, past and present diagnosis;
- g. Family History:** Past family history should be documented as part of the initial visit;
- h. Allergies:** Medication allergies must be in a prominent location within the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently noted. Allergies to environmental allergens, food, pets, etc., or any other untoward reactions should also be noted;
- i. Social History:** There should be documentation of a social history including, but not limited to, the assessment of tobacco, alcohol, and drug use/abuse;
- j. Problem List:** There should be a current problem list, which includes significant past and current illnesses and medical conditions. Problem list reflects significant and /or continuing problems. A health maintenance record should be present even if there are no documented relevant problems;
- k. Immunization Documentation:** Documentation of immunizations by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine;
- l. Physical Examination:** Document pertinent physical examination, relevant to the chief complaint and the purpose of the visit and objective findings;
- m. Vital Signs:** Document vital signs, consistent with the patient's chief complaint, relevant problem and/or diagnosis;
- n. Diagnosis/Assessment:** Document diagnosis and/or medical impression based on assessment or physical exam; diagnosis must be consistent with the findings and documented within the record;
- o. Previous Problems:** Unresolved problems and/or chronic problems from prior office visits should be addressed in subsequent visits;
- p. Treatment Plan/ Plan of care:** A plan of diagnosis (lab testing, x-rays, etc.), therapies administered and prescribed, and management (medications dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented; Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases;
- q. Continuity of Care, Outcome, Follow-Up Care, Calls or Visits:** Communications between the provider and the member with reference to follow-up care, test results (outcomes), etc., should be documented to indicate continuity of care; summaries of emergency services and hospital discharges with appropriate medically indicated follow-up; system in place to schedule appropriate preventive health service;
- r. Medication List:** Patient's current medications should be listed with start and end dates, if applicable;

- s. Studies:** All lab(s), studies, x-ray, EKGs, referral (s), should be included and documented within the record. The practitioner should initial study results and consultations in order to certify provider review. Abnormal test(s) results documented and discussed with the member;
- t. Referral / Disposition Documentation:** All specialist referrals and consultations reports are filed within the medical record. There should be documentation that the practitioner has discussed abnormal results with member, along with recommendations and instructions;
- u. Hospital Care:** Medical records shall contain summaries of all emergency care and hospital discharges with appropriate, medically indicated follow-up;
- v. Chart Organization:** The practitioner should maintain a uniform medical record system, ensure completeness of the information, accuracy, and current clinical recording and reporting with respect to services. The record should include a separate section for progress notes and the recording of results from diagnostic tests;
- w. Advance Directives:** Medical record has documentation of Advanced Directives and/or Living Will discussion with any patient over the age of 18; include copies of any Advance Directives executed by the member;
- x. Member Non-compliance:** Document missed appointments or failure to follow up on M.D. instructions in order to demonstrate non-compliance. Recommend follow up with patient via letter or phone call when appointment(s) are missed.

Medical Records Reviews

Clear Spring Health's Quality Improvement Department reviews providers' medical records as part of Clear Spring's re-credentialing process, "potential" quality of care issues, clinical grievance and/or appeals, claims investigations, inappropriate care / treatment and for HEDIS reporting.

The purpose of medical record reviews is to determine compliance with Clear Spring's standards for documentation, coordination of care and outcome of services; to evaluate the quality and appropriateness of the treatment and to promote continuous improvement. These reviews are performed to evaluate compliance with requirements and do not define standards of care or replace a practitioner's judgment.

Medical record reviews will be conducted every three (3) years for re-credentialing purposes. All primary care providers and high volume specialists are subject to medical record reviews. At the conclusion of the review, the reviewer will notify the provider of any deficiencies. The provider must achieve a score of at least 80% in order to meet Clear Spring's standards. Providers who do not meet standards have up to 30 calendar days to address the items identified and provide a written response, signed by the provider. If applicable, Clear Spring will issue a Corrective Action Plan (CAP), or provide guidance and other tools to assist the provider in improving documentation. If a provider fails to comply with a Corrective Action Plan, the provider will be reported to the Credentialing Committee for further action.

Transfer of Medical Records

Primary care practitioners are required to transfer member medical records or copies of records within seven (7) days of request, at no charge to the member to:

- Newly designated primary care practitioners
- Newly designated Managed Care Organization
- Centers for Medicare and Medicaid Services and / or any governmental or accrediting agency.

PROVIDER PERFORMANCE MEASURES

A. Preventable Serious Adverse Events/Hospital Acquired Conditions (HACs) and Never Events

The CMS Program established on August, 2007 initiatives are to track “serious preventable events” and “hospital acquired conditions” that occur in a hospital setting.

Potential Preventable Serious Adverse Events, Hospital Acquired Conditions and Never Events are identified by several internal and external mechanisms such as, but not limited to, claims payment retrospective reviews, utilization management case review, complaint and grievance review, fraud and abuse investigations, practitioner/providers, delegates, and state and/or federal agencies.

Once a potential event has been identified, an extensive review is conducted by the Quality Improvement at Clear Spring Health. The process includes a medical record review and possible telephonic or mail communication with the practitioner/ provider. Upon final determination of an actual event occurring, Clear Spring Health will notify the practitioner/provider by mail that payment denial or retraction will occur. Should you have any questions, please contact Clear Spring Health’s Provider Services Department at 1-866-788-3640.

B. Member Satisfaction Survey

The Quality Improvement department monitors providers’ compliance with Clear Spring’s standards through periodic data collected from the CAHPS survey. The Consumer Assessment of Health Plan Survey (CAHPS) is administered to our members by CMS each year between January and April. The survey’s goal is to evaluate the experience Medicare members have had with the Clear Spring services and our participating providers.

Quality Improvement reviews survey data to obtain a general indication of how well Clear Spring meets member expectations and to identify areas where improvement is needed. Specific areas of focus are:

- Our members’ overall ratings of their:
 - Health Plan
 - Provider office staff performance
- Assessment of member perceptions related to:
 - Customer service
 - Getting needed care
 - Getting care quickly
 - How well doctors communicate
 - Shared decision making
 - Coordination of care
 - Health promotion and education

All areas surveyed above are used to facilitate comparisons among all Medicare health plans, which are meaningful to health care consumers.

Clear Spring Health will make the CAHPS survey results available to both members and providers. We encourage that providers review the results and share the results with office staff and incorporate appropriate changes in their offices, as applicable.

C. Provider Satisfaction Survey

A provider satisfaction survey is conducted annually by Provider Relations Department to obtain the providers' perspective on and satisfaction with Clear Spring's services and program. Provider participation in the survey is highly encourage and your feedback is very important to us. Clear Spring inform providers of the survey results and actions for improvement through provider bulletins, newsletters, website, meetings or training sessions.

D. Health Effectiveness Data and Information Set (HEDIS)

Healthcare Effectiveness Data and Information Set (HEDIS) is the set of annual performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). It is used to establish accountability with the goal of improving the quality of health care. HEDIS is one of the most widely used health care performance measures in the United States, and allows consumers to compare health plan performance to other plans and to national or regional benchmarks.

Clear Spring will be reporting HEDIS data sets on an annual basis. HEDIS reporting includes 75 measures across the following eight domains of care:

- Effectiveness of Care
- Access / Availability of Services
- Satisfaction with the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices
- Health Plan Descriptive Information

Although many of the measures are obtained through claims/encounter data, there may be additional information that may be missing or can only be found in the member's medical record. The QI department performs medical record abstraction to close any information gap and consequently, supplement data to improve the measurement rates.

The process of medical record data abstraction is in compliance with, and permitted by, the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, 45 CFR 164.506, and does not require consent or authorization from the member. Clear Spring is ethically and legally bound to protect, preserve and maintain the confidentiality of any protected health information that is obtained through medical records abstraction process.

The HEDIS medical record abstraction process usually begins in March. Prior to requesting medical records, or on-site visit, your office will be contacted. Based on the number of medical records to be abstracted, the Quality staff will make the determination if an on-site visit is necessary. The QI department will send information about the visit and explain its data collection process. Chart abstractions may also involve the mailing, faxing or emailing of certain chart components for off-site review. The number of medical records to be reviewed will be based on the number of members meeting HEDIS criteria and receiving care at the provider office.

Clear Spring requires that all providers support and cooperate with the HEDIS process. We expect that chart abstractors and reviewers to be given full access to medical records and to be allowed to copy or scan appropriate supporting documentation.

We are ready to help when providers and their office staff need training to participate in required HEDIS projects. Providers can request consultation and training in the following areas:

- Information about the year's selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for improvement of HEDIS rates

COORDINATION OF CARE

If a primary care practitioner or specialty care practitioner directs a member to an emergency room for treatment, the specialty care practitioner is required to immediately notify the hospital emergency room of the pending arrival of the patient for emergency services. The specialty care practitioner is required to notify the primary care practitioner of the emergency services within one (1) business day when the emergency room visit occurs over a weekend. Members should be directed to the closest appropriate emergency provider.

Member Outreach

Member Services representatives may call members to verify or coordinate services, to facilitate referrals coming into the Utilization Management Department and to encourage member compliance with appointments. Another important component of member outreach, which is conducted by the Care Management Department, is post-discharge calls to members. These activities ensure that the member receives quality care and services and achieve positive outcomes.

Concurrent Review

Concurrent review is a targeted review that is performed during a hospital and skilled nursing facility stay. The review is performed to confirm the appropriateness of the setting in meeting the medical needs of the member and to initiate the member's discharge planning process. In general, the concurrent review process examines the length of stay and medical necessity and appropriateness of the admission and/or continued hospital stay.

The Nurse Care Managers performs the concurrent review activities. The reviews are conducted either onsite and/or telephonic. On occasions, a provider or facility will be notified of cases that do not meet coverage criteria for continuation of services. The provider or facility is responsible for providing clinical documentation to support coverage decisions.

Upon receiving the supporting documentation, Clear Spring Health may consider such factors as the number or length of services, the location of services, and/or the member's severity of illness and intensity of service to determine whether the services meet the definition of medical necessity for coverage purposes only. If coverage criteria is NOT met, the Care Manager will provide notification to the provider, facility and in some situations, the member.

Discharge Planning

The discharge planning process is a collaborative effort between Clear Spring Health's Concurrent Reviewers, the hospital/facility care manager, the member, and the admitting provider. The main goal of discharge planning is to ensure the coordination and quality of medical services through the post-discharge phase of care.

Providers and facilities are required to provide clinical information to support discharge decisions under the following circumstances:

- An extension of the approval is needed. The extension must be requested prior to the expiration of the approved days.
- The member's discharge plan, which indicates that transfer to an alternative level of care, is appropriate.
- The member is in need of a complex plan of treatment, which includes home health services, home infusion therapy, total parental nutrition and/or multiple or specialized durable medical equipment identified prior to discharge.

The Nurse Care Managers can conduct onsite and/or telephonic reviews to support the discharge planning efforts in order to coordinate health services prior to the discharge.

Clear Spring may assist, but is not required to, help identify health care community resources following an inpatient stay.

Members who are discharged from the hospital receive a written notice called "Important Message from Medicare". When discharge from a facility such as a Skilled Nursing Facility (SNF) or when home health services are to be discontinued, members receive a notice called "Notice of Medicare Non-Coverage". These notices provide information and instructions to members regarding their right to appeal the decision. All members receive these documents, not only those who may disagree with a non-coverage determination.

HEALTH SERVICES

Service Authorization Requests

(Pre-Certifications)

The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who may benefit from case management or disease management.

Authorization is the responsibility of the ordering or admitting provider and can be obtained by completing a [Prior Authorization Request Form](#) and sending it to Clear Spring Health's Utilization Management Department. The Utilization Management Department assesses the medical necessity and appropriateness of services using nationally recognized criteria, such as MCG® Guidelines, the Centers for Medicare and Medicaid Services' (CMS) definition of medical necessity and CMS National and Local Coverage Determinations when authorizing the delivery of healthcare services to members. MCG®

Guidelines are used in conjunction with the member's benefit plan and the provider's recommendation to approve, append and/or deny services.

Providers must submit the appropriate clinical supporting documentation for review with the authorization request or the authorization will NOT be processed. Documentation should include:

- Medical records that describes the planned treatment, including the medical rationale for the services being requested, lab reports, radiology reports, etc.
- All pertinent medical information supporting the requested treatment and/or procedure.

NOTE: Non-Participating providers must complete a Prior Authorization Request Form; sign the attestation for a one time out of network agreement and submit a W9.

Expedited Reviews:

The Utilization Management Department will process an expedited review for a member with a life-threatening condition, or for a member who is currently hospitalized and needs specialized services not covered under the hospitalization, or to authorize a treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

For expedited requests, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the request and written notification to the member and provider will be provided.

Standard Reviews:

For standard precertification requests, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires. Notification will be sent to the requesting provider and member in writing on all standard authorization determinations no later than 14 calendar days from the receipt of the request.

A 14-day extension may be granted if the member requests it or if we have a need for additional information and the extension of time benefits the member (for example, if additional medical records are needed in order to change a potential denial decision).

The Utilization Management Department is committed to assuring prompt, efficient delivery of healthcare services. The Utilization Management Department can be contacted between the hours of 8 AM and 5 PM, Monday through Friday at 1-866 689-8761. When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message and a Utilization Management Representative will return the call the next business day. Urgent requests or questions are directed to call 1-866 689-8761.

Inpatient Hospital Services Authorizations

(Inpatient Pre-Certifications)

All request for inpatient hospital services and/or admissions must include appropriate supporting medical documentation, such as treatment plans, test results, medical history, needed to determine medical necessity to issue the authorization. The supporting medical information will help the Utilization Management Department facilitate the authorization process.

- A. Direct Hospital Admissions – the primary care provider or specialist can refer a member directly to a participating hospital of an inpatient admission. The hospital, primary care provider or specialist can obtain authorization numbers. All direct hospital admissions are subject to review and approval by the Medical Director.
- B. Non-Urgent or Elective Hospital Admission – the primary care provider or specialist may request the admission. Authorization requests must be submitted to Clear Spring Health’s Utilization Management Department at a minimum of 72 hours prior to the admission.

Inpatient hospital admissions are all reviewed for medical necessity and must be approved by the Medical Director.

Medicare Outpatient Observation Notice (MOON)

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. This law amended Section 18669(a)(1) of the Social Security Act by adding new subparagraph (Y) that requires hospitals and critical access hospital (CAHs) to provide written notification and oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours at the hospital or CAHS.

- The MOON is a form that must be delivered before the member received 24 hours of observation as an outpatient.
- If the member is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.
- The start time of Medicare observation services is measured as the clock time observation services are initiated in accordance with a physician’s order.
- The MOON notice is required to be delivered to psychiatric hospital.

Further information about the MOON can be found in CMS site: <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html>

Instructions on how to complete the MOON can be found at: <http://www.cam.gov/Medicare/Medicare-General-Information/BNI/Downloads/CR9935-MOON-Instructions.pdf>

Penalties for Not Obtaining Approval for Requested Services

Depending on the member’s benefit plan, payment may be delayed, reduced or in some circumstances, withheld, if approval is not obtained when required. If there are extenuating circumstances that delayed

the authorization process, the provider should advise the Utilization Management Department when requesting an authorization.

Out of Network Authorization Requests

(Out of Network Pre-Certifications)

Occasionally, a member may need to see a healthcare professional outside of Clear Spring Health's provider network. When the need for out-of-plan services arises, the primary care practitioner must contact Clear Spring Health's Utilization Management Department to obtain an authorization. The Utilization Management Department will review the request and arranges for the member to receive the necessary medical services with a specialty care practitioner in collaboration with the recommendations of the primary care practitioner. Best effort will be made to locate a healthcare professional within an accessible distance to the member.

Second Opinions

A member may request second opinions from a qualified health care professional. When requesting a second opinion consultation, Clear Spring Health recommends that the practitioner refer the member to an in-network qualified health care professional that is not in practice with the practitioner who rendered the first opinion. If an in-network, qualified health care professional is not available, contact Clear Spring Utilization Management Department to assist in arranging and obtaining an authorization for the second opinion of an out-of-network provider at no additional cost to the member.

Emergency Care and Services (ER)

Federal and state regulations prevent us from requiring members to contact a primary care practitioner, specialist or the plan prior to seeking emergency care. The decision by a member to seek emergency care is based upon "prudent layperson" standard. Per CMS guidelines: "An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Members are instructed to call 911 and/or go to the nearest emergency room for treatment if they believe that they are having a medical emergency. Medical emergencies include and are not limited to: severe chest pain, shortness of breath, uncontrolled bleeding, broken bones, sprains, burns, poisoning, convulsions and extended fever.

All Clear Spring Health members or responsible party is informed that they should contact their primary care practitioner prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, Clear Spring Health realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition. In these cases, the member may contact the specialist for instructions. Clear Spring request that a member contact their primary care physician within 48 hours of the ER visit to schedule follow-up care.

Physicians, specialist and covering physician must provide advice, consultation, and access to care appropriate for each member’s medical condition.

- All life-threatening conditions must be referred to the nearest emergency room.
- All providers must notify Clear Spring Health of known emergency room visits and emergency room admissions.
- Providers directing members to an emergency room for treatment are required to notify the emergency room of the pending member arrival.
- Specialty care providers referring members to the ER are required to notify the primary care provider of member’s emergency service visit. If the emergency room visit occurs during a weekend, the specialist must provide notification within one (1) business day of referral.

Emergency services are NOT REQUIRED to have prior authorization and CANNOT be denied retrospectively for eligible members.

Service Denials

Clear Spring may deny a pre-certification request for several reasons:

- Member is not eligible;
- Service is not a covered benefit;
- Member has exhausted his or her benefits;
- Services is not deemed medically necessary (based on utilization guidelines).

Clear Spring Health will notify you in writing of any adverse decision (partial or complete) within standard referral time frames. The notice will state the reasons for the decision and also inform of the right to file an appeal. If the notice is not received within 14 calendar days of your request for services, you may assume the decision is a denial, and an appeal may be filed.

Self-Referrals

All Clear Spring Health members are encouraged to coordinate care with their primary care practitioner prior to receiving specialty services except for the services that can be accessed by self-referral. Members may refer themselves for the following PREVENTIVE types of care.

The following Preventive Care Guidelines have been adopted by Clear Spring Health and are the recommendations by the U.S. Preventive Services Task Force.

PREVENTIVE CARE GUIDELINES

Adults 25-64 Years

Screenings	Frequency
General Physical Exam	Annual *
Height / Weight	Periodically *
BMI	Routinely

Blood Pressure	Routinely
Total blood cholesterol (TC and HDL-C)	Routinely for men and women 20 years and older
Colorectal Cancer Screening Fecal Occult Blood Test (FOBT)	Annually beginning at age 50
Colorectal Cancer Screening Colonoscopy	Every 10 years beginning at age 50
Colorectal Cancer Screening Sigmoidoscopy	Every 5 years beginning at age 50
HIV Screening	Routinely, for all adults at risk of HIV infection
Syphilis screening	Periodically, for all persons at increased risk
Hepatitis B and C	Routinely for all adults at increased risk
Lung Cancer Screening	Annual screening with low dose computed tomography in adults' ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
Tuberculosis Screening	Annual screening with low dose computed tomography in adults' ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
Vision Screening	Annually or more often for Diabetic members
Glucose Test	Annually for those members at increased risk
Hearing Assessment	Annually
Oral Exams/Cleaning	Bi-annually
Female Screenings	Frequency
Clinical Breast Exam (Ages 20 to 40 yrs.)	Every 3 years
Clinical Breast Exam (Age 40 >)	Annually
Mammogram	1-2 years for women age 40 and older
Papanicolaou (Pap)	Every 1 to 3 years for sexually active female beginning at age 18. Annual Pap if Cancer or if cervix remaining and post hysterectomy
Chlamydia Screening	Routinely – For all sexually active females
Gonorrhea Screening	Routinely – For all sexually active females including those that are pregnant
Male Screenings	Frequency
Testicular Screening	Annually for <ul style="list-style-type: none"> • Men 40 yrs. of age and older of African-American descent • Men 40 yrs. of age and older with an affected first-degree relative • Men 50 yrs. of age or older
Immunizations	Frequency
Rubella serology or vaccination history	Recommended once for all females of childbearing age
Tetanus-diphtheria (Td)	Boosters every 10 yrs. or as recommended
Influenza	Annual, at risk
Hepatitis B	Ask physician
Other Preventions	
Aspirin Therapy	Men 40 years and older Postmenopausal women Young people with risk factors for CHD
Multivitamins with folic acid	Females planning/ capable of pregnancy
Asymptomatic bacteriuria	Routine, urine culture at 12-16 weeks of gestation for all pregnant women
Depression Screening	Routinely
Chemoprevention of Breast Cancer	Females at high risk for breast CA and at low risk for adverse effects of chemoprevention. Inform patients of the potential benefits and harms of chemoprevention
Symptoms of Endometrial Cancer	Presence of unexpected bleeding or spotting
Physician Discussion Topics / Health Risk Factors	
Diet and Exercise	Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
	Regular physical activity
	Adequate Calcium intake
	Avoid underage drinking / illicit drug use
	Avoid tobacco use

Substance Use	Discuss harmful effects of smoking / alcohol / drug use on fetal and child health
Sexual Behavior	Sexually Transmitted Disease (STD) Screening
	Prevention of unintended pregnancy / abstinence
	Avoiding high-risk behavior
	Unintended pregnancy
Injury Prevention	Bicycle / motorcycle / ATV / Helmet -safety
	Lap and shoulder seat belts
	Smoke detectors
	Firearm safety
	CPR training for parents/caregivers
	Occupational Hazards
Domestic Violence / Abuse	Routinely
Dental Health	Regular dental visits
	Floss, brush and fluoride

Adults 65 Years and Older

Screenings	Frequency
General Physical Exam	Annual *
Height / Weight	Periodically *
BMI	Routinely
Blood Pressure	Routinely
Total blood cholesterol (TC and HDL-C)	Routinely for men and women 20 years and older
Colorectal Cancer Screening Fecal Occult Blood Test (FOBT)	Annually beginning at age 50
Colorectal Cancer Screening Colonoscopy	Every 10 years beginning at age 50
Colorectal Cancer Screening Sigmoidoscopy	Every 5 years beginning at age 50
Cologuard Test	Annually beginning at age 50
Hepatitis B	Screening for Hepatitis B in persons at high risk for infection
Hepatitis C Screening	Screening for Hepatitis C infection in persons at high risk for infection. USPSTF recommends one-time screening to adults born between 1945 and 1965.
Lung Cancer Screening	Annual screening with low dose computed tomography in adults' ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
HIV Screening	Routinely, for all adults at risk of HIV infection
Syphilis screening	Periodically, for all persons at increased risk
Diabetes Monitoring / Management	Glucose monitoring and self-management training, periodically
Bone Mass	At risk, periodically
Vision Screening	Annually (more often for Diabetics)
Glucose Test	Annually for at risk
Hearing Assessment	Annually
Oral Exams/Cleaning	Bi-Annually
Female Screenings	Frequency
Mammogram	1-2 years for women age 40 and older
Papanicolaou (Pap)	Not recommended, if recent screening have yielded normal Pap results, total hysterectomy or 3 or more normal cytology results within 10 years
Gonorrhea	Routinely, for all sexually active women, including those that are pregnant
Osteoporosis Screening	Routinely
Male Screenings	Frequency
Prostate Test	Annual PSA for males after age 50
Testicular Exam	Annually

AAA (Abdominal Aortic Aneurysm Screening)	One time screening by ultrasonography in men aged 65 to 75 who have ever smoked
Immunizations	Frequency
Tetanus-diphtheria (Td)	Boosters every 10 years or as recommended
Influenza	Annually
Pneumococcal	Once by age 65
Hepatitis B	Ask physician
Other Preventions	
Aspirin Therapy	Men 40 yrs. and older. Postmenopausal women Young people at risk factors for CHD
Diabetic Preventive Screening Retinal eye Exam	Annually
Diabetic Preventive Screening Foot Exam	Annual – 4 times a year; comprehensive and educational
Diabetic Hgb A1C Screening	Annually ; every 6 months for insulin dependent patients
Depression Screening	Routinely
Osteoporosis Screening	Routinely, recommended for women age 65 and older; screening to begin at age 60 if woman is at increased risk for fractures
Chronic Illness Care	Periodically
Physician Discussion Topics / Health Risk Factors	
Diet and Exercise	Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
	Regular physical activity
	Adequate Calcium intake
Substance Use	Avoid underage drinking / illicit drug use
	Avoid tobacco use
	Discuss harmful effects of smoking / alcohol / drug use on fetal and child health
Sexual Behavior	Sexually Transmitted Disease (STD) Screening
	Prevention of unintended pregnancy / abstinence
	Avoiding high-risk behavior
	Unintended pregnancy
Injury Prevention	Bicycle / motorcycle / ATV / Helmet -safety
	Lap and shoulder seat belts
	Smoke detectors
	Firearm safety
	CPR training for parents/caregivers
	Occupational Hazards
Domestic Violence / Abuse	Routinely
Dental Health	Regular dental visits
	Floss, brush and fluoride

- **Frequency of the preventive screenings should be discussed with the physician**

NEW TECHNOLOGY

Any new technology identified during the Utilization Management review process, and requiring authorization for implementation of the new technology will be forwarded to the Medical Director for authorization. If there is a question about the appropriate governmental agency approval of the technology, the Medical Director will investigate the status of the technology with the agency, consult appropriate specialists related to the new technology, and/or utilize a nationally recognized contracted services for information related to the new technology. The technology will also be investigated through CMS National and Local Coverage Determinations. If the technology has not been reviewed by appropriate governmental regulatory bodies, the Medical Director will discuss the need for the

specifically requested technology with the primary care practitioner and may consult with a participating specialist from the Clear Spring Health expert panel regarding the use of the new technology. The new technology review will be presented to the Clear Spring Health QI Committee. If it is determined that no other approved technology is available and/or the Medical Director and consultants feel that the possibility for a positive outcome would be achieved with the use of the new technology, approval may be given. Clear Spring will consider those specific medical items, services, treatment procedures or technologies not specifically identified as non-covered or non-reimbursable by Medicare as defined within National Coverage Determinations.

POLICIES AND PROCEDURES

Clear Spring Health has developed policies and procedures to provide guidelines for identifying and resolving issues with practitioners who fail to comply with the terms and conditions of the applicable Practitioner Agreement and Clear Spring Health policies and procedures.

Policy Changes

In order for Clear Spring Health to be in compliance with Federal and State Laws, Regulations and Regulatory Bulletins governing the Medicare and Medicaid Program in the course of providing services, Providers and their staff will be bound by all applicable federal and state Medicare and Medicaid laws and regulations. Providers will comply with all applicable instructions, bulletins and fee schedules promulgated under such laws and all applicable program requirements of regulatory agencies regarding the Medicare and Medicaid programs.

Additionally, providers need to be aware that no regulatory order or requirement of the Centers for Medicaid and Medicare, Departments of Insurance or any other state or federal agencies shall be subject to arbitration with Clear Spring Health.

Practitioner Education and Sanctioning

Clear Spring Health practitioners will be monitored for compliance with administrative procedures, trends of inappropriate resource utilization, potential quality of care concerns and compliance with medical record review standards. Practitioner education is provided through Quality Improvement Nurses, Provider Relations Representatives and Clear Spring Health Medical Directors. Network practitioners who do not improve through the provider education process will be referred to the Clear Spring Health Quality Improvement/Utilization Management Committee for evaluation and recommendations.

CMS GUIDANCE ON MEDICARE MARKETING ACTIVITIES

Below is the CMS guidance on provider marketing activities as detailed in the Medicare Marketing Guidelines
Provider-Based Activities.

Although providers may not be fully aware of all plan benefits and costs and may face conflicting incentives when acting as a Plan/Part D Sponsor representative, Plans/Part D Sponsors may not prohibit

contracted providers from engaging in discussions with beneficiaries should a beneficiary seek advice. To ensure that providers do not appear to be a Plan/Part D Sponsor agent, Plans/ Part D Sponsors must ensure through their agreements with providers, that contracted providers are advised of the need to remain neutral when assisting with enrollment decisions. Plans/Part D Sponsors should ensure that a provider assists a beneficiary in an objective assessment of his/her needs and potential options to meet those needs. Plans/Part D Sponsors should ensure that any assistance provided to a beneficiary by a contractual, co-branded, or otherwise affiliated provider, results in a plan selection that is always in the best interest of the beneficiary.

Plans/Part D Sponsors may not allow contracted providers to:

- Offer scope of appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of Plans/Part D Sponsors
- Offer anything of value to induce enrollees to select them as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for enrollment activities
- Distribute materials/applications in an exam room

Plans/Part D Sponsors may allow contracted providers to:

- o Provide the names of Plans/Part D Sponsors with which they contract and/or participate
- o Provide information and assistance in applying for the LIS
- o Make available and/or distribute plan marketing materials in common areas
- o Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at [http:// www.medicare.gov/](http://www.medicare.gov/) or 1-800-MEDICARE
- o Share information with patients from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" (from <http://www.medicare.gov/>), or other documents that were written by or previously approved by CMS

CLAIMS AND BILLING

Claims General Information

Procedures for Clear Spring are as follows:

- Payment for CPT and HCPCS codes are covered to the extent that they are HIPAA compliant. Clear Spring Health utilizes CMS place of service codes to process claims, and they are the only place of service codes that are accepted.

- Hospitals should bill on an original UB-04 Form, and other providers, including ancillary providers should bill using an original CMS-1500 (08-05) Form.
- Clear Spring Health does accept bills through electronic data interchange (EDI) and encourages facilities and providers to submit claims via this format.
- Paper and EDI claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form. Paper claims will be handled just like rejected EDI claims and will not be loaded in Clear Spring Health's claims system. Providers will be held to Clear Spring Health's timely filing policies in regards to submission of the initial and corrected claims.
- Correct/current member information, including Clear Spring Health Member ID Number, must be entered on all claims. The format is 8 or 12 digits for the Clear Spring member number. Clear Spring Health member number or HIC number in alpha and numeric format will be accepted on Electronic claims. Clear Spring Health prefers that the Clear Spring Health ID number be submitted to assure that the claim is processed under the correct individual.
- Please allow four to six weeks for a remittance advice. It is the practitioner's responsibility to research the status of a claim.
- Providers can submit an electronic 276 Health Care Claim Status Inquiry transaction to Change Healthcare to verify the status of a claim. Change Healthcare will return a 277 Health Care Claim Status response transaction.
- Clear Spring Health is secondary to any commercial plan. Claims must be submitted within Clear Spring Health's timely filing guidelines.
- Inpatient hospital claims must be submitted with an MS-DRG Code.
- Providers of obstetric services are reimbursed on a global basis for deliveries. Individual visits are not reimbursed and should not be billed.

Timely Filing

Please review your provider agreement for information regarding timely filing. Providers are encouraged to submit a complete original, initial CMS-1500 (08-05) or UB-04 Form. If you bill on paper Clear Spring will only accept paper claims on a CMS-1500 (08-05), or a UB-04 Form. No other billing forms will be accepted.

Providers must bill within 180 calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when Clear Spring is secondary. An original bill along with a copy of the EOB is required to process the claim. Requests for reviews/corrections of processed claims must be submitted within 180 calendar days from the date of the corresponding remittance advice. All claims submitted after the 180-day period following receipt of the EOB or after the 180-day follow-up period from the date on the remittance will be denied.

Any claim that has been submitted to Clear Spring but does not appear on a remittance advice within 60 days following submission should be researched by calling Clear Spring's Provider Services Department to inquire whether the claim was received and/or processed.

Electronic Claims Submission

Clear Spring can accept claims electronically through Change Healthcare. Clear Spring encourages practitioners to take advantage of our electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster Claims Submission and Processing
- Reduced Paperwork
- Increased Claims Accuracy
- Time and Cost Savings

For submission of professional or institutional electronic claims for Clear Spring Health, the Clear Spring Health Payer ID is 66009.

Requirements for Submitting Claims to Clear Spring through Change Healthcare

To submit claims to Clear Spring Health please note the Clear Spring Health Payer ID Number is 66009. Claims submission requires a Clear Spring Health assigned 10-digit member identification number, the member number field allows 6, 8, or 12 digits to be entered. Please note, it is **not** acceptable to submit a claim with the members HIC number.

In addition to edits that may be received from Change Healthcare, Clear Spring has a second level of edits that apply to procedure codes and diagnosis codes. Claims can be successfully transmitted to Change Healthcare but if the codes are not currently valid they will be rejected by Clear Spring. Providers must be diligent in reviewing all acceptance/rejection reports to identify claims that may not have successfully been accepted by Change Healthcare and Clear Spring Health Plan. Edits applied when claims are received by Clear Spring will appear on an EDI Report within the initial acceptance report or Claims Acknowledgment Report. A claim can be rejected if it does not include required NPI(s) and current procedure and diagnosis codes. To ensure that claims have been accepted via EDI, providers should receive and review reports provided by Change HealthCare

If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically. You may also call Change Healthcare directly at 1-866-371-9066.

Clear Spring will accept electronic claims for services that would be submitted on a standard CMS-1500 (08-05) or a UB-04 Form. However, the following cannot be submitted as attachments along with electronic claims at this time:

- Claims with EOBs
- Services billed by report

HIPAA 5010

The 5010 version of the HIPAA electronic transactions is required to support the transfer of ICD-10 diagnosis code and ICD-10 procedure code data on claims and remittances.

Only version 5010 transactions will be accepted. The billing provider address submitted on claims must be a physical address. Claims submitted via Change Healthcare or will be rejected if a P.O. Box number

is submitted as the billing address. To prevent claims from being rejected, please be sure to submit a physical address as the billing address.

Electronic Remittance Advice/Electronic Funds Transfer

Providers may receive electronic claims remittance advice (ERA). Clear Spring uses Change Healthcare to transfer the 835 Version 5010x Healthcare Claim Remittance Advice to claim submitters.

The Companion Documents, which are located in the *Forms and Reference Materials Section* of this Manual, provide information about the 835 Claim Remittance Advice Transaction that is specific to Clear Spring and Clear Spring's trading partners. Companion Documents are intended to supplement the HIPAA Implementation Guides. Rules for format, content, and field values can be found in the Implementation Guides available on the Washington Publishing Company's website at www.wpcedi.com.

Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts and errors.

Providers may receive claims payments via electronic funds transfer (EFT). Providers must first be set-up to receive ERA and complete the EPayment Enrollment Authorization Form located on the Change HealthCare website at <https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms> or by calling ChangeHealthCare at 866-506-2830, Option 2.

Claims Review Process

Clear Spring will review any claim that a provider feels was denied or paid incorrectly. The request may be conveyed in writing (per instructions below), or verbally through Clear Spring's Provider Services Department if the inquiry relates to an administrative issue. Please forward hard copy information via mail to the Claims Review Department along with all of the appropriate documentation, i.e. the actual claim, medical records, and notations regarding telephone conversations, in order to expedite the review process. Initial claims that are not received within the timely filing limit will not qualify for review. All follow-up review requests must be received within 180 calendar days of the initial remittance advice.

Clear Spring cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit a Refund Form or a letter that contains all of the information requested on this form located in the Forms and Reference Materials Section of this manual.

The form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to EOB from other insurance carriers and your refund check should be mailed to:

**Clear Spring Health Care
P.O. Box 4048
Scranton, PA 18505-9875**

Administrative Claims Review

Claims that need to be reviewed based upon administrative or processing issues are handled by a Provider Services Representative via a phone call to Clear Spring Health Plan. For inquiries requiring documentation or received in the mail, Claims Review Representatives evaluate whether the documentation attached to the claim is sufficient to allow it to be reconsidered. Claims that qualify for adjustments will be reprocessed and claim information will appear on subsequent remittance advices. Claims that do not qualify for reconsideration will be forwarded to the Appeals Department for review. All review requests must be received within 180 days of the initial remittance advice.

Please refer to the *Appeals and Grievances Section* of the manual for information on procedures for Appeals submitted by providers on behalf of a member.

Claims inquiries for administrative reviews should be mailed to:

**Clear Spring Health Care
P.O. Box 4048
Scranton, PA 18505-9875**

Coordination of Benefits

Some Clear Spring Health members have other insurance coverage. Clear Spring follows Medicare coordination of benefits rules. Clear Spring does not deny or delay approval of otherwise covered treatment or services unless the probable existence of third party liability is identified in Clear Spring's records for the member at the time the claims are submitted.

Please note the following criteria applies and designates when Clear Spring is not the primary plan for Medicare covered members:

- Enrollee is 65+ years and covered by an Employer Group Health Plan (EGHP) because of either current employment or current employment of a spouse of any age and the employer employs 20 or more employees.
- Enrollee is disabled and covered by an Employer Group Health Plan because of either current employment or a family member's current employment, and the employer that sponsors or contributes to the Large EGHP plan employs 100 or more employees.
- For an enrollee entitled to Medicare solely on the basis of end-stage renal disease and Employer Group Health Plan coverage (including a retirement plan), the first 30 months of eligibility or entitlement to Medicare.
- Workers' compensation settlement proceeds are available.
- No-fault or liability settlement proceeds are available.

To receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's Explanation of Benefits, the practitioner should submit a claim to Clear Spring Health Plan. The practitioner must:

1. Follow all Clear Spring authorization and billing procedures.
2. File all claims within timely filing limits as required by the primary insurance carrier.

3. Submit a copy of the primary carrier's EOB with the claim to Clear Spring within 180 days of the date of the primary carrier's EOB.
 4. The amount billed to Clear Spring must match the amount billed to the primary carrier. Clear Spring will coordinate benefits; the provider should not attempt to do this prior to submitting claims.
- Members seeking care, regardless of primary insurer, are required to contact their primary care practitioner and use participating providers or obtain appropriate authorization for healthcare professionals outside of the network.

BILLING

Billing Procedures

A "clean claim" as used in this section means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under Medicare.

In addition, a claim shall be considered "clean" if the appropriate authorization has been obtained in compliance with Clear Spring's Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS.

1500 (08-05) Form (or their replacement with CMS designations, as applicable) or an acceptable electronic format through a CLEAR SPRING-contracted clearinghouse:

1. Patient name;
2. Patient medical plan identifier;
3. Date of service for each covered service;
4. Description of covered services rendered using valid coding and abbreviated description;
5. ICD-10 surgical diagnosis code(s) (as applicable);
6. Name of practitioners/providers and applicable/required NPI numbers;
7. Provider tax identification number;
8. Valid CMS place of service code(s);
9. Billed charge amount for each covered service;
10. Primary carrier EOB when patient has other insurance;
11. All applicable ICD-10-CM diagnosis codes—inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD-10-CM diagnosis code;
12. MS-DRG code for inpatient hospital claims.

Clear Spring processes medical expenses upon receipt of a correctly completed CMS-1500 (08-05) Form and hospital expenses upon receipt of a correctly completed UB-04. Sample copies of a UB-04 and a CMS-1500 (08-05) Form can be found in the Forms and Reference Material Section of this manual. A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink.

Clear Spring requires all providers to submit claims according to the updated National Provider Identification (NPI) submission procedures. These changes went into effect January 1, 2013 as mandated by the Patient Protection and Affordable Care Act (ACA) of 2010. The Final Rule, published in the April 27, 2012 Federal Register, is applicable to all claims submitted to Clear Spring Health. Below please find a few highlights of the ACA requirements and Clear Spring policies and procedures to support these requirements.

- NPIs for billing providers are required to be reported on paper claims in addition to electronic claims
- For imaging and clinical laboratory services and items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as well as home health services, the NPI of the ordering/referring provider is required in addition to the NPI of the billing provider on paper claims and EDI claims.

Paper and EDI Claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form and just like rejected EDI claims will not be loaded in Clear Spring's claims system. Providers will be held to Clear Spring's timely filing policies in regard to submission of the initial and corrected claims.

NOTE: Applicable Paper Claim Fields:

- **CMS-1500** The following fields are to be reported as indicated:
 - Field 17b – NPI of Referring Provider (for imaging, clinical laboratory, DMEPOS, and home health)
 - Field 24J (b) – NPI of Rendering Provider (if applicable) Field 32a – NPI of Service Facility (if applicable)
 - Field 33a – NPI of Billing Provider (required)
- **UB-04** The following fields are to be reported as indicated:
 - Field 56 – NPI of Billing Provider (required)
 - Field 76 – NPI of Attending Physician (required) Field 77 – NPI of Operating Physician (if applicable) Field 78 & 79 – NPI of Other Physician (if applicable)

All claims must have complete and accurate ICD-10-CM diagnosis codes for claims consideration. If the diagnosis code requires, but does not include the fourth or fifth digit classification, the claim will be denied.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained in the claim is true, accurate and complete.

Clear Spring's claim office address is:

**Clear Spring Health Care
P.O. Box 4048
Scranton, PA 18505-9875**

Any questions concerning billing procedures or claim payments can be directed to Clear Spring's Provider Services Department at 877-384-1241.

Hospital Services

Hospital claims are submitted to Clear Spring on a UB-04. To assure that claims are processed for the correct member, the member's ten-digit Clear Spring identification number must be used on all claims. To aid in the recording of payment, patient account numbers recorded on the claim form by the practitioner are indicated in the Patient ID field on the Clear Spring remittance advice. Please review field numbers below carefully as many of them differ from the former UB-92 format.

UB-04 Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for Electronic claims submissions

Field	Description	Requirements
1	Provider Name, Address, City, State, Zip, Telephone, Fax, Country Code	Required
2	Pay to Name, Address, City, State, Zip	Required If Different from Billing Provider in Field 1
3a	Patient Control Number	Required
3b	Medical Record Number	Not Required
4	Type of Bill	Required – If 4 Digits Submitted, the Lead 0 will be Ignored
5	Federal Tax Number	Required
6	Statement Covers Period	Required
7	Unlabeled Field	Not Used
8a	Patient Name	Required
9	Patient Address	Required
10	Birthdate	Required
11	Patient Sex	Required
12	Admission Date	Required for Inpatient and Home Health
13	Admission Hour	Not Required

14	Type of Admission/Visit	Required, If Inpatient
15	Source of Admission	Required
16	Discharge Hour	Not Required
17	Patient Status	Required
18-28	Condition Codes	May be Required in Specific Circumstances (Consult CMS Criteria)
29	Accident State	Not Used
30	Unlabeled Field	Not Used
31-34	Occurrence Codes and Dates	May be Required in Specific Circumstances (Consult CMS Criteria)
35-36	Occurrence Span Codes and Dates	Required, If Inpatient
37	Unlabeled Field	Not Used
38	Responsible Party Name and Address	Not Required
39-41	Value Codes and Amounts	Required, If Inpatient
42	Revenue Codes	Required
43	Revenue Descriptions	Required
44	HCPCS/Rates/HIPPS Codes	Required, If Outpatient
45	Service Dates	Required, If Outpatient
46	Service Units	Required
47	Total Charges	Required
48	Non-covered Charges	Required, If Applicable
49	Unlabeled Field	Not Used
50	Payer Identification	Required
51	Health Plan ID	Not required
52	Release of Information Certification Indicator	Required
53	Assignment of Benefits	Not Used
54	Prior Payments	Required, If Applicable
55	Estimated Amount Due from Patient	Not Required
56	National Provider ID	Required – NPI Number

57	Other Provider ID	Clear Spring Health® Practitioner Identification Number should be entered on paper claims only- legacy number reported as secondary identifier to NPI on electronic claims
58	Insured's Name	Required, If Applicable
59	Patient Relationship to Insured	Required, If Applicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Clear Spring Member Identification Number Required
61	Insurance Group Name	Required, If Applicable
62	Insurance Group Number	Required, If Applicable
63	Treatment Authorization Code	Required, If Applicable
64	Document Control Number	Not Required
65	Employer Name	Required, If Applicable
66	Diagnosis and Procedure Code Qualifier	Required
67	Principal Diagnosis Code	Required (Coding for Present on Admission data required)
67A- 67Q	Other Diagnosis Codes	Required (Coding for Present on Admission data required)
68	Unlabeled Field	Not Used
69	Admitting Diagnosis Code	Required
70A- 70C	Patient Reason for Visit	Not Required
71	Prospective Payment System (PPS) Code	Required for DRG Code – If 4 Digits Submitted, the Lead 0 will be Ignored
72	External Cause of Injury Codes	Not Used
73	Unlabeled Field	Not Used
74	Principal Procedure Code and Date	Required, If Applicable
74A- 74E	Other Procedure Codes and Date	Required, If Applicable
75	Unlabeled Field	Not Used

76	Attending Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
77	Operating Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
78-79	Other Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
80	Remarks	May be Required in Specific Circumstances (Consult CMS Criteria)
81	Code – Code Field	Optional (Consult CMS Criteria)

CMS-1500 (08-05) Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for Electronic claims submissions

Field #	Description	Requirements
1	Insurance Type	Required
1a	Insured Identification Number	Clear Spring Health® Member Identification Number
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Patient Status	Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Other Insured's Date of Birth, Sex	Required, If Applicable
Field	Description	Requirements
9c	Employer's Name or School Name	Required, If Applicable
9d	Insurance Plan Name or Program Name	Required, If Applicable

10	Is Patient Condition Related to: a. Employment b. Auto accident c. Other accident	Required, If Applicable
10d	Reserved for Local Use	Not Required
11	Insured's Policy Group or FECA Number	Required
11a	Insured's Date of Birth, Sex	Required, If Applicable
11b	Employer's Name or School Name	Required, If Applicable
11c	Insurance Plan Name or Program Name	Required, If Applicable
11d	Is There Another Health Benefit Plan?	Required, If Applicable
12	Patient or Authorized Person's Signature	Required
13	Insured's or Authorized Person's Signature	Required
14	Date of Current: Illness OR Injury OR Pregnancy	Required, If Applicable
15	If Patient has had Same or Similar Illness, Give First Date	Not Required
16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable
17	Name of Referring Practitioner or Other Source	Required, If Applicable
17a, B	Identification Number of Referring Practitioner	
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Reserved for Local Use	May be Required in Specific Circumstances (Consult CMS Criteria)
20	Outside Lab	Not Required
21	Diagnosis or Nature of Illness or Injury	Required
22	Medical Resubmission Code	Not Required
23	Prior Authorization Number	Not Required
24a	Date(s) of Service	Required

24b	Place of Service	Required
24c	Type of Service	Not Required
24d	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24e	Diagnosis Code Pointer	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Not Required
24i	ID Qualifier	Required, if applicable
24j	Rendering Provider ID	Not Required
25	Federal Tax Identification Number	Required
26	Patient Account Number	Not Required
27	Accept Assignment	Not Required
28	Total Charge	Required
29	Amount Paid	Not Required
30	Balance Due	Not Required
31	Signature of Practitioner or Supplier including degrees or credentials	Clear Spring Individual Practitioner Name and Date Required
32	Service Facility Location Information	Facility Name and Address where Services were Rendered Required
33	Billing Provider Info and Phone #	Clear Spring Vendor (Payee) Name, Address, and Phone Number Required. NPI and Clear Spring Legacy Number should be Entered.

APPEALS AND GRIEVANCES

Introduction

Clear Spring Health members have the right to communicate dissatisfaction with the quality of care that they receive, the timeliness of services, or decisions made by Clear Spring or its providers. CMS separates these into two categories: grievances and appeals.

A “grievance” is any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which Clear Spring Health or one of our plan providers provides health care services, regardless of whether any remedial action can be taken.

A complaint is any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by a member made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the member believes he or she is entitled.

A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care. Examples of grievances include:

- Any matter pertaining to the contractual relationship between the member and the Plan;
- Availability, coverage, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to our utilization review programs;
- Complaints regarding claims payment, handling, or reimbursement for health care services;
- Complaints regarding member issues, member behavior, adequacy of facilities, providers, or other similar issues.
- If the member disagrees with our decision to process your appeal request for a service or to continue a service under the standard 30 calendar day time frame rather than the expedited 72-hour time frame.

If you have a question about what type of complaint process to use, please call Clear Spring Member Services Department at 877-384-1241.

Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complaint, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

How to File a Grievance

Generally, grievances should be filed directly with Clear Spring Health Plan, but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement Organization (QIO). The QIO for Colorado, Illinois, North Carolina and Virginia is KEPRO.

Members are encouraged to contact Clear Spring Health Member Services first in order to be provided with immediate assistance. Our staff will try to resolve any complaint over the telephone. If a written response is required or requested, one will be provided. Clear Spring employs a formal, multi-disciplinary process to review member grievances.

Members may file a grievance by:

- Calling our Member Services Department at 877-384-1241 (TTY: 711)
- Mail - **Clear Spring Health**
Attention: Grievances
P.O. Box 4107
Scranton, PA 18505
- Fax – 855-382-6674
- To mail or fax a grievance, an Clear Spring Grievance Form may be used which can be found at www.ClearSpringHealthCare.com

Who May File a Grievance

A member or the member's authorized representative may file a grievance.

Providers may file a grievance on behalf of the member if they have been designated as the member's authorized representative and can supply the member's written consent to this designation.

When to File a Grievance

Grievances must be filed within 60 calendar days of the date of the incident.

Timeframes for Resolution

Grievances must be resolved as expeditiously as the member's case requires, based on the member's health status, but no later than 30 calendar days after the date the Plan receives the oral or written grievance. We may extend this time frame by up to 14 calendar days if you request the extension or if we need additional information and the extension of time benefits you (for example, if we need additional medical records that could change a denial decision). We must make a decision no later than the end of any extension period. If we extend the time frame, we will notify you.

Expedited Grievances

A member or the member's authorized representative may file expedited grievances in the following circumstances:

- When we have extended the timeframe to make an Organization Determination.
- When we have extended the timeframe to resolve a standard request for Reconsideration.
- When we have refused to grant a Member's request for an expedited Organization Determination.
- When Clear Spring has refused to grant a Member's request for an expedited Reconsideration (Appeal).

Expedited grievances must be resolved within twenty-four (24) hours of receiving the request. All affected parties will be notified of the decision by telephone within twenty-four (24) hours of filing the Expedited Grievance, and a letter explaining the decision will follow within three (3) days.

Quality Improvement Organization Review (QIO)

Complaints concerning the quality of care received under Medicare may be investigated and acted upon by Clear Spring Health under the internal grievance process or by an independent organization called the Quality Improvement Organization (QIO) or by both. For example, if member believes that his or her pharmacist provided the incorrect dosage of a prescription or was prescribed a medication in error, the enrollee may file a complaint with the QIO in addition to or instead of a complaint filed under the plan sponsor's grievance process. For any complaint filed with the QIO, Clear Spring must cooperate with the QIO in resolving the complaint.

How to File a Quality of Care Complaint with the QIO

QIOs are assigned regionally by CMS. For members who reside in the below states, quality of care complaints filed with the QIO must be made in writing to the following addresses:

For Illinois, North Carolina and Virginia:

KePRO QIO
5201 W. Kennedy Blvd, Suite 900
Tampa, FL 33609
Toll Free: 1-844-455-8708
Fax 1-844-834-7129
TTY 1-855-843-4776

For Colorado:

KePRO QIO
Rock Run Center, Suite 100
5700 Lombardo Center Dr.
Seven Hills, OH 44131
Toll Free: 1-844-430-9504
Fax 1-844-878-7921
TTY 1-855-843-4776

Appeals

A reconsideration consists of a review of an adverse organization determination or termination of services decision, the evidence and findings upon which it was based, and any other evidence that the parties submit or that is obtained by Clear Spring Health, the QIO, or the independent review entity.

The parties to an organization determination for purposes of an appeal include:

- The enrollee (including his or her representative);
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than Clear Spring Health) determined to have an appealable interest in the proceeding.

A non-contract provider, on his or her behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the member regardless of the outcome of the appeal.

Who May Request a Reconsideration?

Any party to an organization determination (including a reopened and revised determination), i.e., an enrollee, an enrollee's representative or physician.

For standard pre-service reconsiderations, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee's behalf without submitting a representative form.

You may contact Clear Spring Health for additional information as to when standard pre-service reconsiderations can be filed without a completed representative form.

How to Request a Standard Reconsideration

Standard reconsideration requests must be submitted to Clear Spring Health in writing by:

**Clear Spring Health
Appeals and Grievances
P.O. Box 4048
Scranton, PA 18505-9875**

A Clear Spring Appeal Form may be used which can be found at www.ClearSpringHealthCare.com

How to Request an Expedited Reconsideration

An enrollee or any physician (regardless of whether the physician is affiliated with Clear Spring Health) may request that Clear Spring Health expedite a reconsideration of a determination, in situations where applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, including cases in which Clear Spring Health makes a less than fully favorable decision to the enrollee. Due to the short time frame for deciding expedited reconsiderations, a physician does not need to be an authorized representative to request an expedited reconsideration on behalf of the enrollee. A request for payment of a service already provided to an enrollee is not eligible to be reviewed as an expedited reconsideration.

To request an expedited reconsideration, a member or a physician must submit a verbal or written request directly to Clear Spring Health. A request to expedite a reconsideration of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function.

Reconsideration Filing Timeframes

Parties have 60 calendar days from the date of the notice of the organization determination or claim denial to file the request for reconsideration.

If a request for reconsideration is filed beyond the 60 day calendar timeframe and good cause for late filing is not provided, Clear Spring Health will forward the request to the independent review entity for dismissal.

Good Cause for Late Filing Exception

If a request for reconsideration is filed beyond the 60 calendar day timeframe and good cause for late filing is provided Clear Spring Health will extend the time frame for filing the request for reconsideration. Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

- The enrollee did not personally receive the adverse organization determination notice, or he/she received it late;
- The enrollee was seriously ill, which prevented a timely appeal;
- There was death or serious illness in the enrollee's immediate family;
- An accident cause important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The enrollee had incorrect or incomplete information concerning the reconsideration process; or
- The enrollee lacked capacity to understand the time frame for filing a request for reconsideration.

The party requesting the good-cause extension may file the request with Clear Spring Health in writing, including the reason why the request was not filed timely. If Clear Spring Health denies an enrollee's request for good cause extension, the enrollee may file a grievance with Clear Spring Health.

Reconsideration Decision Timeframes

Clear Spring Health will issue a decision to the member or the member's representative within the following timeframes from the date the Plan receives the request:

- Standard Pre-Service Request: 30 calendar days
 - Timeframe will be extended by up to 14 calendar days if the enrollee requests an extension or if Clear Spring Health justifies a need for additional information. In the event Clear Spring Health extends the timeframe it will notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if he or she disagrees with Clear Spring Health's decision to grant itself an extension.
- Retrospective Request: 60 calendar days
- Expedited Request: 72 hours

Regarding Hospital Discharge

There is a special type of appeal that applies only to hospital discharges. If a member feels that the Clear Spring coverage of a hospital stay is ending too soon, the member or his or her authorized representative can appeal directly and immediately to the Quality Improvement Organization (QIO). Quality Improvement Organizations are assigned regionally by the Centers for Medicare and Medicaid Services (CMS).

The QIO for Colorado, Illinois, North Carolina and Virginia is KePro. The QIOs are groups of health professionals that are paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review. One must act very quickly to make this type of appeal, and it will be decided quickly.

If a member believes that the planned discharge is too soon, the member or his or her authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. "The Important Message from Medicare" document given to the member within two days of admission and copied to the member within two days of discharge provides the appeal information as well as the QIO name and telephone number.

In order to request a QIO review regarding a hospital discharge, the member or his or her authorized representative must contact the QIO no later than noon the day of discharge. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one calendar day after it has received the request and all of the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the

member will have no financial liability until noon of the day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, we will continue to cover the hospital stay for as long as it is medically necessary.

If the member or his or her authorized representative does not ask the QIO for a review by the deadline, the member or authorized representative may ask Clear Spring for an expedited appeal. If the member or authorized representative asks us for an expedited appeal of the planned discharge and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an IRE review overturns our decision.

Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) Services

There is another special type of appeal that applies only when coverage will end for SNF, HHA or CORF services. If a member feels that coverage for these services is ending too soon, he or she can appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

If Clear Spring Health and/or the care provider decides to end coverage for SNF, HHA or CORF a written Notice of Medicare Non-Coverage (NOMNC) must be delivered to the member at least two (2) calendar days before coverage ends. The member or authorized representative will be asked to sign and date this document. Signing the document does not mean that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in the provider's records.

Quality Improvement Organization (QIO) Review

For these types of services, members have the right by law to ask for an appeal of a termination of coverage. The member or his or her authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day following the day the notice is received. If the notice is received more than two (2) days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, the QIO will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical information, talk to the doctor, and review other information that Clear Spring provides to the QIO. It is very important that the provider immediately faxes all of the member's medical records to the QIO for their review. Clear Spring will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for the member. The QIO will make this decision within one full day after it receives the information necessary to make a decision. If the QIO decides in favor of the member, will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the

advance notice. Neither Original Medicare nor Clear Spring will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or his or her authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited appeal. It is important to note that if the member or authorized representative requests an expedited appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If Clear Spring staff decides upon expedited appeal review that services are medically necessary to continue, we will continue to cover the care for as long as medically necessary. If the decision is not in the member's favor, we will not cover any of the care that was provided beyond the termination date, and the member may be financially responsible.

IRE Review

Clear Spring will notify the member and provider in writing when an appeal has been forwarded to the IRE for review. The member may request a copy of the file that is provided to the IRE for review. The IRE will review the request and make a decision about whether Clear Spring must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to sixty (60) calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to thirty (30) calendar days to issue a decision.

For expedited appeals regarding medical care, the IRE has up to seventy-two (72) hours to make a decision. These timeframes can be extended by up to fourteen (14) calendar days if more information is needed and the extension is in the member's best interest.

The IRE will issue its decision in writing to the member (or authorized representative) and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge.

Administrative Law Judge Review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or his or her authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. The ALJ will hear the case, weigh all of the evidence and make a decision as soon as possible.

The ALJ will notify all parties of the decision. The party against which the decision is made has the opportunity to request a review by the Medicare Appeals Council/Departmental Appeal Board. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council

The party against whom the ALJ decision is made has the right to request the review by the Medicare Appeals Council (MAC). This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a Federal Court Judge; however, the Federal Court Judge will only review cases when the amount in controversy meets the minimum requirement.

Federal Court

The party against whom the Medicare Appeals Council decision is made has the right to file the case with Federal Court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the Federal Court Judge will not review it and there is no further right of appeal.

Acting as an Authorized Representative

Clear Spring will accept requests made by the member and/or his or her authorized representative or the prescribing physician or other prescriber or a non-participating provider involved in the member's care. A member may have any individual (relative, friend, advocate, attorney, congressional staff member, member of advocacy group, or suppliers, etc.) act as his or her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

In order to act as a representative, the member and representative must complete the Appointment of Representative Form, which can be found online at <https://www.ClearSpringhealthplan.com/>

A representative must sign the appointment within thirty (30) calendar days of the member's signature. The appointment remains valid for a period of one year from either the date signed by the party making the appointment or the date the appointment is accepted by the representative, whichever is later. The appointment is valid for any subsequent levels of appeal on the claim or service in question unless the member specifically withdraws the representative's authority.

If the requestor is the member's legal guardian or otherwise authorized under State law, no appointment is necessary. Clear Spring will require submission of appropriate documentation, such as a durable power of attorney.

A physician who is providing treatment to a member (upon providing notice to the member) may request an appeal on the member's behalf without having been appointed as the member's representative.

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation. Further, the provider appointed must acknowledge in a signed, dated statement that the member will not be held financially responsible for payment for the services under review. Providers who do not have a contract with Clear Spring must sign a "Waiver of Liability" statement, which can be found in the Forms and Reference Material Section of this manual, that the provider will not require the member to pay for the medical service under review, regardless of the outcome of the appeal.

It is important to note that the appeals process will not commence until Clear Spring receives a properly executed AOR or for non-participating providers, a properly executed Waiver of Liability statement.

INTRODUCTION TO CREDENTIALING

Who is Credentialed?

Practitioners: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS), Doctor of Optometry (OD), Master's level and Doctorate of Psychology (Ph.D), Doctorate of Philosophy (Ph.D) and Clinical Social Workers. (This listing is subject to change.)

Extenders: Physician Assistant (PA), a Certified Nurse Midwife (CNM), a Certified Registered

Nurse Practitioner (CRNP), Master level Clinical Nurse Specialist (CNS) and a Certified Nurse Practitioner (CNP). (This listing is subject to change.)

Facility and Ancillary Service Providers: Hospitals, Nursing Homes, Skilled Nursing Facilities, Home Health, Rehabilitation Facilities, Ambulatory Surgical Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Clinical Laboratories, Outpatient Physical Therapy and Speech Therapy providers, and Facilities providing mental health and substance abuse services. (This listing is subject to change.)

Purpose of Credentialing

Credentialing is the process of performing a background investigation, as well as validation of a practitioner and provider's credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of, to include but not limited to, malpractice histories, quality of care concerns and licensure status. Clear Spring prides itself on the integrity and quality of the composition of the practitioner and provider networks.

Credentialing Standards

Clear Spring has established credentialing and recredentialing policies and procedures that meet CMS, DOH, DPW, and NCQA standards.

All information must be current and up-to-date to begin the credentialing process. Therefore, it is important to provide Clear Spring with either your CAQH ID on the CAQH Provider Data Form or submit all applications and attachments in a timely manner with the most current information available.

Clear Spring's standards include but are not limited to, the following:

- A current, unrestricted license.
- Fully completed and signed application, which includes a National Provider Identifier (NPI) number
- Curriculum Vitae and/or Work History to include month and year
- Copy of current, unencumbered DEA certificate, if applicable
- Current hospital admitting privileges for PCPs
- Acceptable malpractice history as subject to decision by Clear Spring Medical Directors and Legal Counsel
- Unexpired professional liability coverage as mandated by state law, of no less than \$1,000,000 per occurrence, \$3,000,000 per aggregate and coverage provided by the Medical Care Availability and Reduction of Error Fund (Mcare) or Federal Tort Coverage
- Active participation in the Medicare and/or Medical Assistance Programs; free of sanctions
- Foreign graduates must submit an ECFMG certificate
- Other items as deemed appropriate

The credentialing/re-credentialing process involves primary sourced verification of practitioner credentials.

Clear Spring's Credentialing Department will notify practitioners, in writing, within thirty (30) calendar days of receiving any information obtained during the credentialing or recredentialing process that

varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information submitted by another party or to correct his or her own information submitted incorrectly. Applicants have ten (10) calendar days from the date of Clear Spring's notification to submit written corrections and supporting documentation to Clear Spring's Credentialing Department. A credentialing decision will not be rendered until the ten (10) calendar days have expired.

Practitioners, upon request, have the right to be informed of the status of their credentialing or re-credentialing application, or a copy of the credentialing criteria. Practitioners also have the right to review any information submitted in support of their credentialing applications except for National Practitioner Data Bank (NPDB), letters of recommendation, and information that is peer review protected. A practitioner must submit a written request to review their credentialing information. All appropriate credentialing information will be sent by Certified Mail, overnight mail or carrier to the practitioner within ten (10) business days from the date that the Credentialing Department received the request.

All practitioners must be re-credentialed at least every three (3) years in order to continue participation within Clear Spring Health. This helps to ensure Clear Spring's continued compliance with Center for Medicare and Medicaid Services (CMS) and), as well as to uphold the integrity and quality of the networks. Extensions cannot be granted.

Clear Spring is committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department as outlined in Clear Spring Health Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

Ongoing and Performance Monitoring

Clear Spring's Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General's (OIG) report, the Medicare Opt Out Listing (CMS), and applicable state disciplinary report. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB) as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a Clear Spring participating practitioner is found on the OIG, Medicare Opt Out List, or applicable state disciplinary action report, the practitioner's file is immediately pulled for further investigation. Depending on severity level of the sanction, the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or immediately terminated. In all instances, the information is reported to the QI/UM Committee.

Monitoring of Member Complaints is conducted on a quarterly basis. The Clear Spring Credentialing Department reviews complaint reports, which reveals member complaints, filed against practitioners. The Credentialing Department will review and investigate all complaints regarding: attitude of provider, provider treatment, quality issues of physician, and any complaints regarding adverse events. If after investigation the complaint is considered viable, it is documented. Depending upon

the severity level of the complaint(s), the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or terminated and outcome presented to Quality Improvement/Utilization Management Committee.

Clear Spring's re-credentialing process includes a comprehensive review of a practitioner's credentials, as well as a review of any issues that may have been identified through a member complaint report and/or quality of care database.

Practitioner Absences

Clear Spring continues to follow NCQA guidelines for practitioners called to active military service, on maternity leave or an approved sabbatical. However, it is the practitioner's or his/her office's responsibility to notify Clear Spring in writing that the practitioner is called to active duty or beginning the leave, as well as an expected return date. The letter should also include the practitioner who will be covering during his or her leave. The Clear Spring Credentialing Department will not terminate the practitioner called to active duty, on maternity leave or on an approved sabbatical, if appropriate coverage is in place. Practitioner/practitioner's office should notify Clear Spring of practitioners return, as soon as possible, but not exceeding ten (10) business days from the practitioners return to the office. The Clear Spring Credentialing Department will determine, based upon the length of time, if the practitioner will have to complete a recredentialing application. If the practitioner requires recredentialing, it must be completed within sixty (60) calendar days of the practitioner resuming practice.

Denial and Termination

In accordance with Clear Spring's business practices, the inclusion of a practitioner in the Clear Spring Practitioner/Provider Network is within the sole discretion of Clear Spring Health Plan.

Clear Spring conducts credentialing in a non-discriminating manner and does not make credentialing decisions based on an applicant's type of procedures performed, type of patients, or a practitioner's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation or disability. Clear Spring understands and abides by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation.

If a practitioner does not meet Clear Spring's baseline credentialing criteria, the QI/UM Committee will make a final determination on participation or continued participation. If a practitioner fails to submit information and/or documentation within requested time frames, processing of the practitioner application may be discontinued or terminated. All requests for re-credentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation.

Denial and termination decisions that are made based on quality concerns can be appealed and are handled according to Clear Spring's Due Process Policy and Procedure. If necessary, the information is reported to the National Practitioner Data Bank and Bureau of Quality Management and Provider

Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as State licensing boards.

Clear Spring Health will notify providers in writing of any decisions to deny, suspend or terminate their privileges to participate in the network

Practitioners who want to request a review of a termination, other than for quality of care concerns, must submit a written request for the review along with any supporting documentation to Clear Spring within thirty (30) calendar days of the date of the certified notification.

Delegated Credentialing

Delegation is the formal process by which Clear Spring has given other entities the authority to perform credentialing functions on the behalf of Clear Spring Health. Clear Spring may delegate certain activities to a credentialing verification organization (CVO), Independent Practitioner Association

(IPA), hospital, medical group, or other organizations that employ and/or contract with practitioners. Organizations must demonstrate that there is a credentialing program in place and the ability to maintain a program that continuously meets Clear Spring's program requirements. The delegated entity has authority to conduct specific activities on behalf of Clear Spring Health. Clear Spring has ultimate accountability for the quality of work performed and retains the right to approve, suspend, or terminate the practitioners and site. Any further sub delegation shall occur only with the approval of Clear Spring and shall be monitored and reported back to Clear Spring Health.