Section 4:
HealthSpan Integrated Care
Medicare Advantage Provider Manual
Utilization Management
# Table of Contents

**SECTION 4: UTILIZATION MANAGEMENT**

- **4.1 Decision Making for Medical Service Requests**
- **4.2 Concurrent Review Process**
- **4.3 Medical Appropriateness Criteria**
- **4.4 Case Management**
  - 4.4.1 Inpatient Case Management
- **4.5 Disease Management**
  - 4.5.1 Distribution of Preventive Care and Clinical Practice Guidelines to Plan Providers
  - 4.5.2 Informing and Educating Practitioners
  - 4.5.3 Outreach Activities for Members
  - 4.5.4 My Chart Manager
- **4.6 Referrals**
  - 4.6.1 Secondary Referrals
  - 4.6.2 Outpatient Referrals for Procedures, Testing and Injectables
  - 4.6.3 Requests for Out-of-Network Authorization
    - 4.6.3.1 Non-Urgent Referral Requests for Out-of-Network Authorization
    - 4.6.3.2 Expedited Referral Requests for Out-of-Network Authorization
  - 4.6.4 Behavioral Health Services
    - 4.6.4.1 Behavioral Health Services Quality Standards
  - 4.6.5 Ob/Gyn
    - 4.6.5.1 Infertility Services Referral Protocol
    - 4.6.5.2 Contraception
  - 4.6.6 Optometry
- **4.7 Precertification**
  - 4.7.1 Non-Urgent Precertification Requests
    - 4.7.1.1 Extensions
  - 4.7.2 Expedited Precertification Requests
    - 4.7.2.1 Extensions
  - 4.7.3 Inpatient Admissions
    - 4.7.3.1 Emergency Hospital Admissions
    - 4.7.3.2 Non-Emergent and Elective Inpatient Hospital Admissions
4.7.3.3 Skilled Nursing Facility (SNF) Admissions ................................................................. 24
4.7.4 Ambulance Transfers ........................................................................................................... 24
  4.7.4.1 Non-Emergent Facility to Facility Ambulance Transfers .......................................... 25
  4.7.4.2 Ambulance Transfers of Stable Patients ................................................................. 25
4.7.5 Home Health Care .............................................................................................................. 25
  4.7.5.1 Home Infusion Therapy .............................................................................................. 26
4.7.6 Hospice Services .................................................................................................................. 26
4.7.7 Bariatric Surgery .................................................................................................................. 26
4.7.8 Transplants ......................................................................................................................... 27
4.7.9 Durable Medical Equipment (DME), External Prosthetics Devices and Orthotic Appliances .................................................................................................................. 27
4.8 ANCILLARY SERVICES ........................................................................................................ 28
  4.8.1 Laboratory Services ........................................................................................................ 29
  4.8.2 Imaging (Radiology) Services ........................................................................................ 29
  4.8.3 Outpatient Physical, Occupational and Speech Therapy Services ......................... 30
4.9 CLINICAL TRIALS .................................................................................................................. 31
4.10 PROCEDURE FOR AUTHORIZATION NOTICES ......................................................... 33
  4.10.1 Out-of-network Referral Provider Guidelines ............................................................ 33
  4.10.2 Referring Plan Provider Guidelines ............................................................................ 33
4.11 DENIED AUTHORIZATIONS ........................................................................................... 33
  4.11.1 Denials for Inpatient Days for Hospitals, Skilled Nursing and Comprehensive Outpatient Rehabilitation Facilities, and Home Health Care .............................................. 34
  4.11.2 All Other Denials .......................................................................................................... 34
4.12 RECONSIDERATIONS AND APPEALS ......................................................................... 34
  4.12.1 Reconsideration of Decisions Following Initial Determination Denial ........................ 35
  4.12.2 Standard Appeal Process of Initial Adverse Pre-Service Determinations ................. 35
  4.12.3 Expedited Pre-Service Appeals .................................................................................. 36
  4.12.4 Plan Provider Post-Service Claim Appeals ................................................................. 37
4.13 PAYMENT DISPUTES .......................................................................................................... 37
4.14 DRUG FORMULARY ............................................................................................................. 39
  4.14.1 Requesting Coverage for Nonformulary Medications .............................................. 39
Section 4: Utilization Management

4.1 Decision Making for Medical Service Requests

Appropriate utilization management contributes to the success of HealthSpan and its Members. The ultimate goal of utilization management is to achieve optimum results by determining what resources are Medically Necessary and appropriate for an individual patient, and to provide those Services to the patient in an appropriate setting in a timely manner. Decisions about what is Medically Necessary and appropriate are based on evidence-based criteria and professional Practitioner’s judgment as well as assessing the individual Member’s medical condition.

Effective utilization management is NOT withholding necessary Services that may result in less than optimum outcomes. Each Practitioner uses his/her clinical expertise to evaluate the care needs of the individual using evidence-based criteria and arranging for those Services in the appropriate setting.

HealthSpan does not offer incentives or additional compensation to Plan Providers or other individuals conducting utilization management activities in return for denial of care.

4.2 Concurrent Review Process

HealthSpan’s Care Management Department performs Concurrent Review of all hospital and/or Facility admissions. This also includes observation stays, home health care requests and outpatient therapies. Onsite hospital reviews as well as telephonic reviews may be performed on a case-by-case basis. The participating hospital and/or Facility’s utilization review department is responsible for providing clinical information to HealthSpan daily or as requested by telephone and/or electronic means. HealthSpan staff may contact the utilization review department as well as the attending physician if further clarification of the Member’s clinical status and treatment plan is necessary. This may include a peer to peer discussion.

Peer to peer review is the process where the attending, treating, or ordering physician requests a peer to peer review with the HealthSpan Physician who made the original Adverse Determination to facilitate further discussion of the case or to share additional information. If the Physician who made the Adverse Determination is unavailable, another HealthSpan Physician reviewer will perform the peer to peer review. Per National Committee for Quality Assurance (NCQA) standards, only the attending, treating or ordering physician or his/her designee can request a peer to peer review.
NOTE: A peer-to-peer review is not an Appeal nor does it take the place of an Appeal.

The HealthSpan nurse uses approved criteria to determine Medical Necessity for acute hospital care. If the clinical information meets HealthSpan’s Medical Necessity criteria, a specified number of days/Services will be approved. If the clinical information does not meet Medical Necessity criteria, the case will be referred to the Physician Advisor/Reviewer. Once the HealthSpan Physician Advisor/Reviewer reviews the case, the staff nurse will notify the attending Physician and the Facility the results of the review. The attending Physician may request a Reconsideration and/or an expedited Appeal of any Adverse Determination (see page 35 of this Manual).

Failure to provide clinical information for Authorized days/Services by the next assigned review date may result in a denial of all days/Services beyond the initial Authorization period, due to untimely clinical review.
4.3 Medical Appropriateness Criteria

Position Statement: All services authorized by the Care Management Department at Health Span will be evaluated to determine medical appropriateness based on the following evidence-based criteria and guidelines:

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Explanation of Application</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>♦ MCG Care Guidelines (formerly Milliman) Inpatient and Surgical Care Guidelines</td>
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<tr>
<td>♦ MCG Care Guidelines (formerly Milliman) Recovery Facility Care Guidelines</td>
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<tr>
<td>♦ MCG Care Guidelines</td>
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<tr>
<td>♦ General Recovery Guidelines</td>
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<td>♦ Physician judgment in collaboration with ER provider</td>
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<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
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<tr>
<td>♦ MCG Care Guidelines Ambulatory Care Guidelines</td>
<td></td>
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<tr>
<td>♦ Official Disability Guidelines</td>
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<tr>
<td>♦ HealthSpan’s Clinicians’ Clinical and Preventive Guidelines:</td>
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<td>- Bariatics</td>
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<td>- Breast Reduction</td>
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<td>♦ HealthSpan Guidelines/Criteria (Intranet)</td>
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<td>- Private Duty Nursing</td>
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<td>- Pediatric Low Vision Aides</td>
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<td>- CDU (Clinical Decision Unit) Manual</td>
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<td>- Residential Treatment</td>
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<td><strong>Ancillary Services</strong></td>
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<tr>
<td>♦ Official Disability Guidelines</td>
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<td>♦ American Society of Addiction Medicine (ASAM) Patient Placement Criteria (required by the Ohio Department of Mental Health and Addiction Services (Ohio MHAS))</td>
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<td>♦ Medicare Regulations (DMERC, Medicare Explained) National Coverage Decisions</td>
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<td>♦ MCG Care Guidelines</td>
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<td>♦ NCCN Guidelines</td>
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<td>♦ Lexicomp</td>
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<td>♦ MCG Care Guidelines</td>
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<td><strong>New Treatments, Technology and Drugs</strong></td>
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<td>♦ Up to Date</td>
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<td>♦ Internet Evidence Based Criteria/HS Intranet</td>
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<td><strong>Transplants</strong></td>
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<td>♦ Facility/Network Selection Criteria</td>
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<td>♦ MCG Care Guidelines</td>
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**Inpatient Care**
- Admission and continued stay criteria:
  - Medical, Surgical & Behavioral
  - SNF
  - Long Term Acute Care Criteria (LTAC)
  - Emergency and Observation Admissions (HUB)

**Outpatient Care**
- Referrals to Specialty Care
- Outpatient Treatment/Procedures
- Outpatient Diagnostics
- Observation Level of Care
- Residential Treatment

**Ancillary Services**
- DME
- Orthotics
- Home Care

**Drugs**
- Chemotherapy
- Other High Cost Drugs

**New Treatments, Technology and Drugs**

**Transplants**
- Optum National Transplant Network
- InterLink National Transplant Network
These criteria are available for review by contacting HealthSpan’s Care Management Department 866-433-1333 (toll-free), option 4. Denials of requests for Service are reviewed by a Physician. Each Adverse Determination letter issued to Plan Providers contains the reason for the denial and explains the right to appeal the decision on behalf of the member. The patient, or his/her authorized representative, receives a similar notice.

4.4 Case Management

The case management process includes arranging care in the appropriate setting for acutely ill, chronically ill, or injured Members on a case-by-case basis that supports the achievement of realistic treatment goals. Nurses and Social Workers work with the Member, the Member’s Primary Care Physician (PCP), the Specialist responsible for follow up care, HealthSpan staff and Plan Providers to develop and implement plans of care to optimize the Member’s level of independence and quality of life. They proactively assess, identify, coordinate, monitor and evaluate medical problems and service needs of the Member’s condition. The PCP is responsible for approving the plan of care and reviewing it with the Case Manager at regular intervals.

4.4.1 Inpatient Case Management

Inpatient case management may involve HealthSpan nurses, case managers and social workers who are working in real time to coordinate a safe discharge plan which may include transitioning a patient from one level of care to another level, and may involve both inpatient and outpatient case management staff.

4.5 Disease Management

HealthSpan is dedicated to helping support clinical practices and providing quality care to all Members. As part of this effort, HealthSpan offers a variety of comprehensive disease management programs to Members, many components of which are available to Plan Providers. Our most well-developed disease management programs are directed toward the following chronic conditions:

- Coronary Artery Disease.
- Depression.
- Diabetes.
- Elder Care.
- Heart Failure.
- Hypertension.
- Weight Management.
Through the use of information technology systems and sophisticated data registries, HealthSpan can identify Members needing medical or nursing interventions. Centralized Patient Care Coordinators support Primary Care Physicians by reaching out to these Members and ensuring that necessary interventions are performed.

In order to confront the growing health concern of heart failure, HealthSpan developed a Heart Failure Care Management Program designed to improve the quality of life for our Members living with heart failure through education, self-management, nutrition counseling, medication management, treatment, and follow-up care. Our multidisciplinary team performs initial evaluations, ongoing follow-up care, education, and communication.

Disease management has always been built into the way HealthSpan delivers care. Addressing co-morbidities (when one person has two or more chronic conditions) is more efficient in a care delivery system designed to manage the total health of each Member. Because we deliver the care our Members need, all of our Practitioners are able to consider every aspect of an individual’s health.

HealthSpan Complete Care programs employ a proactive approach, which includes the following elements, to deliver coordinated, integrated care to our Members with chronic conditions:

- Use of population-based information systems and innovative technology (e.g., disease-specific registries tracking systems, Interactive Voice Recognition (IVR's) to support outreach and other automated systems to support clinical functions and risk-stratified case finding.
- Extensive decision-support systems for Practitioners (e.g., clinical practice guidelines, CarePath [HealthSpan’s electronic medical record system]) which provide automated reminders/prompts, standing orders, which embed evidence-based practice into HealthSpan care processes.
- Specifically designed delivery systems to support health and disease management through the use of outreach efforts for clinical and preventive care gaps, care managers and centralized improvement specialists when appropriate, group appointments when more effective, etc.
- Unmatched resources available for Member self-management and engagement, including educational content, health classes, health tools, and Total Health Assessments as well as online healthy lifestyle programs and support.
- Measurements of clinical effectiveness through continual monitoring and reporting upon our clinical performance.
HealthSpan Members with specific chronic medical conditions—such as diabetes, hypertension, cardiovascular disease, and heart failure—do not need to actively enroll in our programs. Members are automatically identified and added to our programs using disease-specific case identification protocols, triggered by information in HealthSpan’s pharmacy, laboratory, outpatient, and hospital discharge data systems.

The following Sections review critical components of HealthSpan’s disease management programs available to Plan Providers and Members.

4.5.1 Distribution of Preventive Care and Clinical Practice Guidelines to Plan Providers
Preventive Care and Clinical Practice Guidelines are based on sound scientific evidence and designed to promote quality care. They have been developed for screening, immunization, education, prenatal care and condition/disease management. Preventive Care and Clinical Practice Guidelines are available on the HealthSpan Providers website at healthspan.org/providers/north-coast. See Section 8.10 of this HealthSpan Medicare Advantage Provider Manual for more information regarding Preventive Care and Clinical Practice Guidelines.

4.5.2 Informing and Educating Practitioners
Plan Practitioners are informed of HealthSpan disease management programs and how to access them via the Provider Manual, under “News and Announcements” on the Providers website at healthspan.org/providers/north-coast, and the Provider Connection newsletter.

4.5.3 Outreach Activities for Members
HealthSpan sends letters monthly to Members newly diagnosed with heart failure and diabetes, describing our disease management programs and how to access them. We also send letters quarterly to Members with these conditions who have not seen their Primary Care Physician in 1 year, reminding the Members to make appointments for follow-up.

4.5.4 My Chart Manager
Members who receive their care at a HealthSpan medical Facility have the ability to manage their health and the health of their family online through My Chart at healthspan.org. My Chart provides Members with instant access to secure health care information online from wherever they have Internet access.

Some of these time-saving features include:
- Emailing a HealthSpan Physicians, Inc. Physician.
• Managing prescriptions.
• Viewing lab results.
• Acting for a family member.
• Viewing past office visit information.
• Viewing Eligibility and Covered Benefits.
• Tracking documented allergies.
• Scheduling or canceling future appointments.
• Viewing immunization records.
• Requesting updates to medical records.

4.6 Referrals

HealthSpan Medicare Advantage Members do not need Referrals from their Plan Primary Care Physicians (PCP) to see In-Network Plan participating Specialists.

Direct Access to Plan Specialists and Providers does not exempt said Providers from abiding by Plan Authorization and Precertification policies and procedures. With the exception of Emergency or urgently needed care, inpatient and outpatient hospital Services, including laboratory, imaging and other studies, must be provided at an In-Network Facility. See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of inpatient and outpatient Services which require Precertification for HealthSpan Medicare Advantage Members. Precertification is a requirement of each Plan Provider’s Agreement and a necessary step for appropriate Claim adjudication and payment.

HealthSpan Medicare Advantage Members do need Referrals from Plan Physicians to see non-participating, out-of-network providers. A Referral is a prospective, written recommendation by a Plan Provider for Specialty medical care, procedures, testing, therapies and equipment and/or supplies. A Referral is not approved until it is Authorized by HealthSpan. See page 12 for instructions regarding the submission of Referrals for out-of-network Services.

Plan Specialists are expected to provide timely feedback to referring Physicians regarding the outcome of consultations, plans of care, and need for further testing and follow up. HealthSpan is able to provide diagnostic, imaging and laboratory testing for Members at HealthSpan Medical Facilities. For a current list of Plan Facilities, access the Provider Lookup at northeastohio.healthspanproviders.org, or contact your designated Provider Relations Department in Cleveland or Cincinnati, or call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m.,
and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to request a HealthSpan Ancillary Provider Directory.

HealthSpan will only pay for Covered Services when HealthSpan Referral and Authorization requirements are met.

NOTE: Retroactive Referral and Precertification requests are not accepted.

4.6.1 Secondary Referrals
The term secondary Referral is used to describe an outpatient Referral from one Plan Specialist to another. HealthSpan Medicare Advantage Members do not need Referrals from Plan Physicians to see In-Network Plan participating Specialists.

Direct Access to Plan Specialists and Providers does not exempt said Providers from abiding by Plan Authorization and Precertification policies and procedures. With the exception of Emergency and urgently needed care, inpatient and outpatient hospital Services, including laboratory, imaging and other studies, must be provided at an In-Network Facility. See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of inpatient and outpatient Services which require Precertification for HealthSpan Medicare Advantage Members. Precertification is a requirement of each Plan Provider’s Agreement and a necessary step for appropriate Claim adjudication and payment. With the exception of Emergency or urgently needed care, Services rendered by an out-of network provider without prior Authorization will be the Member’s financial responsibility.

HealthSpan Medicare Advantage Members do need Referrals from Plan Physicians to see out-of-network providers. See page 12 for instructions regarding the submission of Referrals for out-of-network Services.

See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of inpatient and outpatient Services which require Precertification for HealthSpan Medicare Advantage Members.

HealthSpan will only pay for Covered Services when HealthSpan Referral and Authorization requirements are met.

NOTE: Retroactive Referral and Precertification requests are not accepted.
4.6.2 Outpatient Referrals for Procedures, Testing and Injectables
HealthSpan Medicare Advantage Members do not need Referrals from Plan Physicians for most outpatient testing performed or provided by In-Network Plan participating Providers.

Direct Access to Plan Specialists and Providers does not exempt said Providers from abiding by Plan Authorization and Precertification policies and procedures. With the exception of Emergency or urgently needed care, inpatient and outpatient hospital Services, including laboratory, imaging and other studies, must be provided at an In-Network Facility. See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of inpatient and outpatient Services which require Precertification for HealthSpan Medicare Advantage Members. Precertification is a requirement of each Plan Provider’s Agreement and a necessary step for appropriate Claim adjudication and payment. Services rendered by an out-of-network provider or facility without prior Authorization will be the Member’s financial responsibility.

Medicare Advantage Members do need Referrals from Plan Physicians for outpatient testing performed or provided by out-of-network providers. See page 12 for instructions regarding the submission of Referrals for out-of-network Services.

HealthSpan will only pay for Covered Services when HealthSpan Referral and Authorization requirements are met.

NOTE: Retroactive Referral and Precertification requests are not accepted.

4.6.3 Requests for Out-of-Network Authorization
If a Plan Provider determines that it is Medically Necessary to refer a Member to an out-of-network practitioners/providers, attach clinical notes to the Care Management Department Referral form (see Appendix F.1 of this HealthSpan Medicare Advantage Provider Manual) indicating the need for that practitioner/provider. Plan Providers may also submit Referral requests via CareLink (see Section 6.17.2 of this HealthSpan Medicare Advantage Provider Manual). To ensure routine Referrals are handled efficiently and timely, complete all areas of the form and include as much clinical information as necessary for appropriate Authorization.

The Referral form allows the Plan Physician to do the following:
- Authorize treatment for the Member.
- Identify the Services the Member requires.
• Communicate pertinent clinical information to the Specialist or Provider.
• Provide Member billing information.

If a Referral request for out-of-network Services is approved, Referrals for Specialists consults are valid for 6 months, unless otherwise indicated. Up to two visits per referral are Authorized, unless otherwise indicated. Each Referral is assigned a unique Authorization number.

In order for an Authorization to be valid:
• Out-of-network Providers must have a completed, written Referral form from HealthSpan.
• The Member must be eligible on the date of Service.
• Services must be rendered between the assigned start date and expiration date of the Authorization to the Specialist or Provider.
• The number of visits made to the Specialist or Provider must not exceed the number of Authorized visits between the corresponding Referral start and expiration date.
• The Services must be rendered as Authorized (e.g. by the named provider and/or at the named facility).
• The procedure or treatment must be medically appropriate for the patient’s diagnosis.
• The procedure or treatment must be performed in an Authorized Plan Provider’s office, or at a Plan Facility as set forth on the Authorization Form.
• The Member’s Plan must cover Services for the stated condition.

4.6.3.1 Non-Urgent Referral Requests for Out-of-Network Authorization
When a Member has made a request for a Service (non-urgent pre-service or non-urgent concurrent), Medical Management must notify the Member of its determination as expeditiously as the enrollee’s health condition requires1, but no later than fourteen (14) calendar days after the date HealthSpan receives the request for a standard organization determination.

1 “Expeditiously as the enrollee’s health condition might require” means that Medical Management must apply, at a minimum, established accepted standards of medical practice in assessing an individual’s medical condition. Evidence of the individual’s condition can be demonstrated by indications from the treating provider or from the individual’s medical record (including such information as the individual’s diagnosis, symptoms, or test results). MMCM Ch. 13 §50.2.1
4.6.3.1 Extensions for Non-Urgent Referral Requests for Out-of-Network Authorization

Medical Management may extend this Member notification time frame up to an additional fourteen (14) calendar days. An extension may be requested by the Member; or, it may be granted if Medical Management justifies a need for additional information and documents how the delay is in the interest of the enrollee.

4.6.3.2 Expedited Referral Requests for Out-of-Network Authorization

A Member or any physician (regardless of whether the physician is affiliated with HealthSpan), may request that Medical Management expedite an organization determination (urgent pre-service and urgent concurrent requests) when the Member or his/her physician believe that waiting for a decision under the standard time frame could place the enrollee’s life, health, or ability to regain maximum function in serious jeopardy. Members and physicians may submit their requests for an expedited organization determination to HealthSpan orally or in writing. Physicians may also provide oral or written support for a Member’s own request for an expedited organization determination.

Medical Management must automatically provide an expedited organization determination if a physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function (the physician does not have to use these exact words). The physician need not be the Member’s representative in order to make the request.

For requests made by a Member, Medical Management must expedite the review of the determination if Medical Management finds that applying the standard time for making the determination could seriously jeopardize the Member’s health, life, or ability to regain maximum function.

The Referrals Care Management Department nurse will decide whether to expedite or not within 72 hours of receipt of the request. If the decision is not to expedite, the nurse will transfer the request to the standard time frame and the request will follow the usual process for initial determinations. The nurse will orally advise the Member and/or physician as appropriate of the decision to transfer the request to the standard timeframe. Written notification of this decision will follow within 2 working days. The enrollee may file a

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2 See MMCM Ch. 13 §50.2 for requirements on how Medical Management must process requests for expedited organization determinations.
3 MMCM Ch. 13 §50.1
Grievance with the HealthSpan Customer Relations Department concerning this decision. The notice sent will include instructions for the enrollee regarding filing an expedited Grievance and the timeframes for such.

If Medical Management decides to expedite the request, it must render a decision as expeditiously as the enrollee’s health condition might require, but no later than seventy-two (72) hours after HealthSpan receives the Member’s request. Medical Management must extend the 72 hour time frame by up to fourteen (14) calendar days if the Member requests the extension.

4.6.3.2.1 Extensions of Expedited Referral Requests for Out-of-Network Authorization

Medical Management may extend the 72 hour time frame by up to fourteen (14) calendar days if Medical Management justifies a need for additional information and documents how the delay is in the interest of the enrollee. When Medical Management extends the time frame, it must notify the Member 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 Medical Management’s decision to grant an extension. Medical Management must notify the Member of its determination as expeditiously as the enrollee’s health condition requires, but no later than the expiration of the extension.

4.6.4 Behavioral Health Services

HealthSpan Members may self-refer to any In-Network Provider for Behavioral Health Services. Members may call any Plan Behavioral Health Provider office location listed in the HealthSpan Provider directory during normal operating hours and speak with a triage clinician. Plan Behavioral Health Providers must be available after hours, 24 hours per day, 7 days per week for assessment, Referral and intervention Services.

Direct Access to Plan Specialists and Providers does not exempt said Providers from abiding by Plan Authorization and Precertification policies and procedures. With the exception of Emergency and urgently needed care, inpatient and outpatient hospital Services, including laboratory, imaging and other studies, must be provided at an In-Network Facility. See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of inpatient and outpatient Services which require Precertification for HealthSpan Medicare Advantage Members. Precertification is a requirement of each Plan Provider’s Agreement and a necessary step for appropriate Claim adjudication and payment.

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4 MMM Ch. 13 §50.1, §50.2.
Plan Providers may call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

4.6.4.1 Behavioral Health Services Quality Standards
HealthSpan has established appointment accessibility standards that each Plan Behavioral Health and Chemical Dependency Provider must meet. See Section 8.9 of this HealthSpan Medicare Advantage Provider Manual for the HealthSpan appointment accessibility standards.

HealthSpan is required by the National Committee for Quality Assurance (NCQA) and HEDIS® (Health Plan Employer Data Information Set) to periodically monitor Plan Behavioral Health Providers to ensure HealthSpan accessibility standards are met. The Behavioral Health Department Access Survey (see Appendix F.3 of this HealthSpan Medicare Advantage Provider Manual) is one tool HealthSpan utilizes to monitor the access to care available for Members seeking behavioral health Services from Plan Providers. This survey is conducted semi-annually by the HealthSpan Network Development and Performance Department for all Plan Provider offices that Members may directly access for care. Each Plan Mental Health or Chemical Dependency Provider will be asked several questions relative to the following:

- The level of clinical competence of staff members assigned to triage incoming Member calls (must be at a minimum of a Registered Nurse or a licensed counselor).
- The appointment availability of all Plan Providers to assess and treat Members with emergent, urgent, routine and follow up needs.
- The availability of the Plan Providers for Members who need assessment and care outside of normal office hours.

Each survey question score is tallied, compared and shared with the Plan Provider. Plan Providers scoring less than 50 percent on any one measure, or less than 90 percent overall, will receive individual follow up from HealthSpan and reassessment.

Patient safety and the reduction of medical errors are important topics that have emerged as major concerns about today’s health care delivery system. The potential for errors is perhaps greater when multiple practitioners/providers provide care for an individual patient without adequate communication regarding findings and therapeutic interventions. For this reason, HealthSpan encourages real time exchange of information among Plan
Providers treating the same patient and periodically monitors to assess whether effective communication is occurring.

It is the policy and expectation of HealthSpan that all Plan Behavioral Health Providers will communicate with the Member’s Primary Care Physician (PCP) via mail, email, fax or telephone regarding a new episode of care and obtain written authorization to release information to the PCP when indicated.

In keeping with the patient safety and quality standards of HealthSpan, we may request retrospective utilization review or quality data concerning Plan Providers and/or Facilities.

### 4.6.4.1.1 Postpartum Depression Screening

Postpartum depression is common in one of seven new mothers. Postpartum onset is defined as occurring in the first 12 weeks after birth. Maternal depression can interfere with mother-infant bonding and have negative effects on the child. Screening for symptoms of depression can lead to earlier recognition and Medically Necessary treatment.

Postpartum depression screening is an important health initiative at HealthSpan. Primary Care Physicians and Plan Ob/Gyn providers are asked to screen new mothers for postpartum depression within 8 weeks of delivery. A sample screening form, the Patient Health Questionnaire (PHQ 9), and the PHQ 9 Scoring Card for Severity Determination are located in Appendix F.4 and 5 of this HealthSpan Medicare Advantage Provider Manual.

Plan Practitioners are responsible for evaluating their patients and making clinically appropriate treatment recommendations. If Plan Providers do not already have a screening tool to use, the PHQ 9 and the Scoring Card can help Practitioners develop an appropriate treatment plan for each patient.

### 4.6.5 Ob/Gyn

HealthSpan Medicare Advantage Members may self-refer to any In-Network Provider for routine Ob/Gyn Services.

Direct Access to Plan Specialists and Providers does not exempt said Providers from abiding by Plan Authorization and Precertification policies and procedures. With the exception of emergency or urgently needed care, inpatient and outpatient hospital Services, including laboratory, imaging and other studies, must be provided at an In-Network Facility. See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of inpatient and outpatient Services which require
Precertification for HealthSpan Medicare Advantage Members. Precertification is a requirement of each Plan Provider’s Agreement and a necessary step for appropriate Claim adjudication and payment.

4.6.5.1 Infertility Services Referral Protocol
HealthSpan Medicare Advantage Members do not need Referrals from their Plan Primary Care Physicians (PCP) to see In-Network Plan participating infertility Specialists.

If a HealthSpan Medicare Advantage Member has tried to conceive after 12 months of regular intercourse (6 months if a woman is over 35), without the use of contraceptives, the Member may need special medical Services to evaluate or treat infertility. Services to determine if infertility exists are not part of the infertility benefit, i.e.: sperm count, evaluation of fallopian tubes for patency. Once infertility is diagnosed however, the treatment of such is infertility Services. This evaluation, if done prior to a referral to an infertility Specialist, would be considered regular gynecology Service.

4.6.5.1.1 Infertility Services Benefits
HealthSpan pays a percentage of the cost of Covered Services for infertility treatment.

The following Services are not covered by HealthSpan. The Member will have 100 percent financial responsibility for these Services and should be made aware of their financial liability prior to rendering Service.

- Services to reverse voluntary, surgically induced infertility.
- The cost of semen, including purchase, storage and cryopreservation.
- Donor eggs and Services related to the procurement and storage of donor eggs.
- Services, other than artificial insemination, for conception by artificial means, including, but not limited to, In-vitro Fertilization, Gamete Intra Fallopian Transfer (GiFT), Zygote Intra Fallopian Transfer (ZIFT), and ovum transplants.
- Infertility Services for a partner who is not a HealthSpan Medicare Advantage Member.
- Services related to a surrogacy arrangement, including, but not limited to, conception, pregnancy or delivery are not covered as a means to correct a Member’s infertility. A surrogacy arrangement is one in which a woman agrees to become pregnant and surrender the baby to another person or persons who intend to raise the child.
Medicare Part D does not cover infertility drugs. If the Member has no drug benefit through an employer group, the Member will pay the full cost of prescription drugs.

Plan Providers may call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

Members may call the HealthSpan Customer Relations Department, 8 a.m. - 8 p.m. daily, 800-493-6004 to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech impaired may call 711 (toll-free TTY). Information regarding Covered Benefits also appears in the HealthSpan Medicare Advantage Evidence of Coverage which is mailed to the Member’s home on an annual basis.

4.6.5.2 Contraception
See Section 10.7 of this HealthSpan Medicare Advantage Provider Manual.

4.6.6 Optometry
HealthSpan Medicare Advantage Members may self-refer to any EyeMed Vision Care Provider for Optometry Services. The EyeMed network includes hundreds of independent and retail Optometrists within the HealthSpan Medicare Advantage Service Area. With the exception of Emergency or urgently needed care, medical treatment of the eye must be provided by an In-Network Ophthalmologist.

HealthSpan Medicare Advantage Members may select an EyeMed Provider by calling the EyeMed Customer Service Department at 866-939-3633 or by accessing the Eye-Med website at eyemed.com. The hearing/speech-impaired may call 866-308-5375 (toll-free TTY).

In addition to routine eye care, some plans cover a hardware rider which provides a dollar allowance for frames, lenses and contact lenses. HealthSpan Members may use their hardware rider at any authorized EyeMed Optometry location.

Medicare Advantage Members may call the HealthSpan Customer Relations Department, 8 a.m. - 8 p.m. daily, 800-493-6004 to verify Covered Benefits and determine what Copayments and exclusions may apply. The hearing/speech impaired may call 711 (toll-free TTY). Information regarding Covered Benefits also appears in the HealthSpan Medicare Advantage
Evidence of Coverage which is mailed to the Member’s home on an annual basis.

4.7 Precertification
Precertification is a determination by HealthSpan that an admission, extension of stay or other health care Service has been reviewed, and based on the information provided, meets the clinical requirements for Medical Necessity under the auspices of the Member’s applicable health benefit plan. See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of inpatient and outpatient Services which require Precertification for HealthSpan Medicare Advantage Members. To precertify, call 866-433-1333 (toll-free).

Upon receipt of a Precertification request, HealthSpan will do the following:
- Verify Member Eligibility.
- Verify that the requested Service is a Covered Benefit.
- Determine if the admitting practitioner is a Plan Provider and if the facility is a Plan Provider for the specific admission, if applicable.
- Determine that the Services are Medically Necessary.

Once processed and approved, an Authorization notice with the Authorization number will be returned by fax to the admitting Physician. A copy will also be sent to the admitting Plan Facility.

4.7.1 Non-Urgent Precertification Requests
When a Member has made a request for a Service (non-urgent pre-service or non-urgent concurrent), Medical Management must notify the Member of its determination as expeditiously as the enrollee’s health condition requires but no later than fourteen (14) calendar days after the date HealthSpan receives the request for a standard organization determination.

4.7.1.1 Extensions
Medical Management may extend this Member notification time frame up to an additional fourteen (14) calendar days. An extension may be requested by the Member; or, it may be granted if Medical Management justifies a need for

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5 “Expeditiously as the enrollee’s health condition might require” means that Medical Management must apply, at a minimum, established accepted standards of medical practice in assessing an individual’s medical condition. Evidence of the individual’s condition can be demonstrated by indications from the treating provider or from the individual’s medical record (including such information as the individual’s diagnosis, symptoms, or test results). MMCM Ch. 13 §50.2.1
4.7.2 Expedited Precertification Requests

A Member or any physician (regardless of whether the physician is affiliated with HealthSpan), may request that Medical Management expedite an organization determination (urgent pre-service and urgent concurrent requests) when the Member or his/her physician believe that waiting for a decision under the standard time frame could place the enrollee’s life, health, or ability to regain maximum function in serious jeopardy. Members and physicians may submit their requests for an expedited organization determination to HealthSpan orally or in writing. Physicians may also provide oral or written support for a member’s own request for an expedited organization determination.

Medical Management must automatically provide an expedited organization determination if a physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function (the physician does not have to use these exact words). The physician need not be the Member’s representative in order to make the request.

For requests made by a Member, Medical Management must expedite the review of the determination if Medical Management finds that applying the standard time for making the determination could seriously jeopardize the member’s health, life, or ability to regain maximum function.

The Referrals Care Management Department Nurse will decide whether to expedite or not within 72 hours of receipt of the request. If the decision is not to expedite, the nurse will transfer the request to the standard time frame and the request will follow the usual process for initial determinations. The nurse will orally advise the Member and/or physician as appropriate of the decision to transfer the request to the standard timeframe. Written notification of this decision will follow within 2 working days.

The enrollee may file a Grievance with the HealthSpan Customer Relations Department concerning this decision. The notice sent will include instructions for the enrollee regarding filing an expedited Grievance and the timeframes for such.

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6 See MMCM Ch. 13 §50.2 for requirements on how Medical Management must process requests for expedited organization determinations.
7 MMCM Ch. 13 §50.1
If Medical Management decides to expedite the request, it must render a decision as expeditiously as the enrollee’s health condition might require, but no later than seventy-two (72) hours after HealthSpan receives the member’s request.\(^8\)

Medical Management must extend the 72 hour time frame by up to fourteen (14) calendar days if the member requests the extension.

### 4.7.2.1 Extensions
Medical Management may extend the 72 hour time frame by up to fourteen (14) calendar days if Medical Management justifies a need for additional information and documents how the delay is in the interest of the enrollee. When Medical Management extends the time frame, it must notify the Member 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 Medical Management’s decision to grant an extension. Medical Management must notify the Member of its determination as expeditiously as the enrollee’s health condition requires, but no later than the expiration of the extension.

### 4.7.3 Inpatient Admissions
See the following Precertification guidelines for emergent and non-emergent inpatient hospital and skilled nursing facility admissions.

#### 4.7.3.1 Emergency Hospital Admissions
In the event that an emergent inpatient hospital admission is needed, including emergent or urgent admits directly from a physician’s office, follow the procedures below in order to expedite reimbursement and facilitate case management:

1. Direct the Member to a HealthSpan Plan Facility where you have privileges or to the nearest emergency room.
2. Authorization of hospital admissions after Emergency evaluation and stabilization is expected. Call 866-433-1333 (toll-free) to obtain Authorization. After business hours, follow the recorded instructions. Inpatient admissions will not be Authorized until Medical Necessity review is completed.
3. Provide the Precertification staff with the following information:
   - Member name.
   - Member Medical Record Number.
   - Name of the Member’s Primary Care Physician (PCP).
   - Name of the admitting Physician.

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\(^8\) MMCM Ch. 13 §50.1, §50.2.
• Admitting hospital or Facility name.
• Date of admission.
• Admitting diagnosis.
• Proposed treatment and length of stay.

Plan Facilities are also responsible for calling the HealthSpan Precertification Line for all inpatient Emergency admissions. Authorization of hospital admissions after Emergency evaluation and stabilization is expected. Call 866-433-1333 (toll-free) to obtain Authorization. After business hours, follow the recorded instructions. **Inpatient admissions will not be Authorized until Medical Necessity review is completed.**

Following Precertification for Medical Necessity, an Authorization notice with the Authorization number will be returned by fax to the admitting Physician. A copy will also be sent to the admitting Plan Facility. HealthSpan will only pay for Covered healthcare Services when HealthSpan Referral and Authorization requirements are met. **This policy includes those instances when HealthSpan is the secondary Payor for HealthSpan Medicare Advantage Members.**

**NOTE:** Only one hospital Deductible is paid per benefit period for HealthSpan Medicare Advantage Members. If a HealthSpan Medicare Advantage Member is transferred from one hospital to another, HealthSpan must pay the covered stay, minus any applicable Member Copayment. Case management is provided to HealthSpan Medicare Advantage Members while in an inpatient setting. Continued stay review in Plan hospitals is required.

**4.7.3.1.1 Hospital Discharge and Repatriation Policy**
The HealthSpan Case Management team (HealthSpan Physician Advisor and staff nurses) review Emergency Department and inpatient cases at hospitals for quality and resource stewardship. HealthSpan may transfer stable patients, when appropriate and agreed to by the physician and Member, to specific Plan Facilities. Physicians and staff at any facilities are able to talk directly with HealthSpan Case Management staff during business hours to facilitate a safe transfer. If there are any issues around approvals/denials, the facility and Member will be notified.

**4.7.3.2 Non-Emergent and Elective Inpatient Hospital Admissions**
Follow the procedures below in order to expedite reimbursement and facilitate case management.
1. For HealthSpan Medicare Advantage Members, call 866-433-1333 (toll-free) or fax to 877-705-2503 to precertify the admission.
2. Provide the Precertification staff with the following information:
   - Member name.
   - Member Medical Record Number.
   - Name of the Member’s Primary Care Physician (PCP).
   - Name of the admitting Physician.
   - Admitting Plan Hospital or Facility name (location of Service).
   - Date of Service.
   - Type of Service requested (for example, inpatient surgery).
   - Procedure code.
   - Patient’s diagnosis.
   - Diagnosis code.
   - Significant patient history (attach Physician notes if indicated).
   - Attach copies of supporting laboratory or imaging test results.
   - Plan of care.

NOTE: Only one hospital Deductible is paid per benefit period for HealthSpan Medicare Advantage Members. If a Medicare Advantage Member is transferred from one hospital to another, HealthSpan must pay the covered stay, minus any applicable Member Copayment. Case management is provided to HealthSpan Medicare Advantage Members while in an inpatient setting. Continued stay review in Plan hospitals is required.

4.7.3.3 Skilled Nursing Facility (SNF) Admissions
SNF admissions require Precertification for HealthSpan Medicare Advantage Members. To precertify, call 866-433-1333 (toll-free).

4.7.4 Ambulance Transfers
HealthSpan will only pay for Covered healthcare Services when HealthSpan Precertification requirements are met. This policy includes those instances when HealthSpan is the secondary Payor for HealthSpan Medicare Advantage Members. Failure to secure Authorization prior to a scheduled transport can result in a denial of payment for the transport.

All ambulance transfers, including air ambulance, will be reviewed against Centers for Medicare and Medicaid Services (CMS) ambulance criteria as described in Chapter 10, Ambulance Services, Paragraph 4 of the Medicare Benefit Policy Manual posted on the CMS website at cms.gov/manuals/Downloads/bp102c10.pdf.

Transportation by wheelchair van is not a Covered Benefit. The Member is financially responsible for wheelchair transportation and the service should be arranged by the transferring facility.
4.7.4.1 Non-Emergent Facility to Facility Ambulance Transfers
To precertify non-emergent ambulance transfers from facility to facility for HealthSpan Medicare Advantage Members, call the HealthSpan Case Management Department at 877-676-6270 or 216-524-5333. After business hours, follow the recorded instructions.

4.7.4.2 Ambulance Transfers of Stable Patients
For HealthSpan Medicare Advantage Members, all ambulance transfers of stable patients, even if the patients have received Emergency Services, are to be arranged through the HealthSpan Case Management Department at 877-676-6270 (toll-free) or 216-524-5333. After business hours, follow the recorded instructions.

4.7.5 Home Health Care
Home Health Care Services require Precertification for HealthSpan Medicare Advantage Members. To precertify, call 866-433-1333 (toll-free) or fax the completed Home Care, Home Rehab and Hospice Services Precertification form (see Appendix F.6 of this HealthSpan Medicare Advantage Provider Manual) to 877-705-2503 (toll-free). The form may be changed from time to time. For the most current form, go to healthspan.org/providers/north-coast to download the correct version. The most current form must be completed in its entirety in order to ensure that all information necessary to issue an Authorization is received. The Precertification form must be signed by a Plan Physician.

To qualify for Covered home health care Benefits, a HealthSpan Medicare Advantage Member must meet the following requirements:

- The Member must be confined to the home. (While a Member does not have to be bedridden to be considered confined to home, there should exist circumstances whereby leaving home requires a considerable and taxing effort and absences from home are infrequent or of relatively short duration).
- The Member is under a Plan Physician’s care.
- The Member is receiving Services under a plan of care established and periodically reviewed by a Plan Physician.
- The Member must be in need of skilled nursing care on an intermittent basis, or home occupational, physical or speech therapy.

Custodial care and/or assistance with activities of daily living are not Covered Benefits.
4.7.5.1 Home Infusion Therapy
If a Member needs home IV Therapy, first fax the completed Home Care, Home Rehab and Hospice Services Precertification form to the HealthSpan Pharmacy at 216-265-6856. Next, call the HealthSpan Pharmacy Department. Monday through Friday, 8:00 a.m. – 5:00 p.m., call 216-265-6855. After hours or weekends, call 800-524-7372 and ask the operator to page the Home Infusion Pharmacist at 216-568-2895 for medication orders.

4.7.6 Hospice Services
Hospice Services DO NOT require Precertification for HealthSpan Medicare Advantage Members.

NOTE: Original Medicare pays for Hospice Services. HealthSpan Medicare Advantage Members can receive hospice Services from any Medicare-certified hospice provider, in or out of the HealthSpan of Ohio Service Area. Since Medicare pays for hospice Services at 100 percent, no Coinsurance is payable by either HealthSpan or the HealthSpan Medicare Advantage Member for these Services.

4.7.7 Bariatric Surgery
HealthSpan covers bariatric surgery for HealthSpan Medicare Advantage Members that meet specific medical criteria. A multi-disciplinary team at HealthSpan reviews each case prior to surgical consultation.

To refer any HealthSpan Medicare Advantage Member for evaluation, submit a completed Care Management Department Referral form (see Section F.1 of this HealthSpan Medicare Advantage Provider Manual) to the Care Management Department. The Bariatric Case Manager will contact the Member to discuss the pre-approval assessment and management program. This program is a mandatory step before any consideration is given for bariatric surgical interventions.

Entry criteria includes the following:
- Documentation of previous failed attempts at weight loss.
- Patients with a BMI at time of assessment of greater than 35, but less than 40, must have at least two or more co-morbidities. Patients with a BMI, at time of assessment, of at least 40, require no co-morbidities. See the Clinical Guideline for Bariatric Surgery for more information. Clinical Guidelines are available on HealthSpan’s Providers website at healthspan.org/providers/north-coast.
- Patients must be at least 18 years old.
Plan Providers may call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

4.7.8 Transplants

The HealthSpan Transplant Department works with our care partners at University Hospitals Case Transplant Institute to provide transplant services for some solid organ transplants. For transplants due to hemolytic / oncology diseases, University Hospitals Case Seidman Cancer Center is our partner for stem cell transplants (autologous and allogeneic). HealthSpan also has extensive resources within the United States top Centers of Excellence (COE) for all transplants with our relationship with INTERLINK Health Services, Inc. and OptumHealth Care Solutions.

The HealthSpan transplant Department follows HealthSpan Medicare Advantage Members through the evaluation process and while the patients are listed. The Transplant Department facilitates Referrals for Members as they are being evaluated. The Transplant Department also works with the center’s staff and physicians during the transplant and post-transplant periods. For more information regarding HealthSpan transplant policies, procedures or criteria, contact the Transplant Department by phone at 216-217-7228.

4.7.9 Durable Medical Equipment (DME), External Prosthetics Devices and Orthotic Appliances

DME, External Prosthetic and orthotic orders require Precertification for HealthSpan Medicare Advantage Members. To precertify, call 866-433-1333 (toll-free) or fax a Physician signed Statement of Medical Necessity or the HealthSpan DME Precertification form (see Appendix F.7 of this HealthSpan Medicare Advantage Provider Manual) to the number indicated at the top of the form. The form must be signed by the ordering Physician. If the item is needed on a same-day basis, or within 24 hours, write “Urgent” at the top of the Precertification form. To ensure Authorizations are handled efficiently and timely, complete all areas of the form and attach as much clinical information as necessary.

Upon receipt of a completed DME Precertification form, HealthSpan Care Management Department staff will do the following:

- Verify Member Eligibility.
- Verify that the requested device is a Covered Benefit.
- Verify that the ordering practitioner is a Plan Provider.
- Apply Centers for Medicare & Medicaid Services’ (CMS) criteria.
HealthSpan has Agreements with a variety of Providers to fulfill DME, external prosthetics devices and orthotic appliances orders. If the Member meets CMS criteria for Covered Services, Authorization will be faxed to a designated Plan Provider for fulfillment. The Authorized Plan Provider will notify HealthSpan of delivery confirmation, service date and billed HCPC codes. Plan Practitioners will only be given Authorization to dispense DME in their medical offices if there is clinical urgency.

If the Member does not meet CMS criteria for Covered Services and/or Eligibility, and/or HealthSpan Eligibility requirements, Care Management Department staff will review the request with the Physician Advisor and notify the prescribing Physician and issue a Benefit Determination in writing to both the Member and the Physician. Examples of exclusions include:

- Dental appliances, arch supports, foot orthotics, corrective shoes, non-rigid appliances and supplies such as elastic stockings and garter belts.
- Experimental or research devices and appliances.
- Replacement or repair necessitated by misuse or loss that is covered under any insurance policy or by any governmental program.
- Deluxe equipment, except when such deluxe features are necessary for the effective treatment of a Member’s condition and required in order for the Member to operate the equipment.
- Equipment usually used for comfort or convenience that is not primarily medical in nature (e.g., bed boards, telephone arms, or portable versus stationary equipment).
- Exercise and hygienic equipment.
- Self-help devices not primarily medical in nature (e.g., sauna bath, elevators).

DME, external prosthetics devices and orthotic appliances Providers should contact the HealthSpan Care Management Department at 866-433-1333 (toll-free) for any re-orders of supplies, extensions or renewed Authorizations. Requests may also be faxed to 216-529-5535.

Plan Providers may call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

4.8 Ancillary Services

The following Sections of this HealthSpan Medicare Advantage Provider Manual summarize guidelines for laboratory, imaging and therapy Services.
4.8.1 Laboratory Services
All outpatient laboratory Services are provided by MercyHealth laboratories or the Plan Facilities identified on the HealthSpan Ancillary Provider directory. Be sure to include an ICD-9 code and Plan Physician signature on all laboratory orders.

See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of laboratory Services that require Precertification, such as genetic testing.

HealthSpan expects your office to submit any laboratory specimens taken in the office to a Plan Facility. Otherwise, your office will be held financially responsible for payment of Services provided by out-of-network laboratories and the Member must be held harmless.

Plan Providers must comply with HealthSpan’s Utilization Review requirements.

For a current list of Plan Facilities, refer to the HealthSpan Provider Lookup website at northeastohio.healthspanproviders.org, or call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to request a HealthSpan Ancillary Provider directory.

Medicare Advantage Members may call the should call the HealthSpan Customer Relations Department, 8 a.m. – 8 p.m. daily, 800-493-6004, to verify Covered Benefits, and to determine what Copayments and exclusions may apply. The hearing/speech impaired may call 711 (toll-free TTY). Information regarding Covered Benefits also appears in the HealthSpan Medicare Advantage Evidence of Coverage which is mailed to the Member’s home on an annual basis.

4.8.2 Imaging (Radiology) Services
All outpatient imaging Services are provided by MercyHealth medical Facilities, or, as permitted, at Plan Facilities as identified on the HealthSpan Ancillary Provider directory. The written imaging order must include an ICD-9 code and the Plan Physician’s signature.

See Appendix A (Precertification Guidelines) of this HealthSpan Medicare Advantage Provider Manual for a list of imaging Services that require Precertification for HealthSpan Medicare Advantage Members. This list may be revised at any time and Plan Physicians are responsible for checking this
list to determine if the Imaging Service is subject to Precertification requirements.

Plan Providers must comply with HealthSpan’s Utilization Review requirements.

For a current list of Plan Facilities, refer to the HealthSpan Provider Lookup website at northeastohio.healthspanproviders.org, or contact either your designated Provider Relations Department in Cleveland or Cincinnati or call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to request a HealthSpan Ancillary Provider directory.

Medicare Advantage Members may call the HealthSpan Customer Relations Department, 8 a.m. – 8 p.m. daily, 800-493-6004, to verify Covered Benefits, to determine where Imaging Services should be provided, and to determine what Copayments and exclusions may apply. The hearing/speech impaired may call 711 (toll-free TTY). Information regarding Covered Benefits also appears in the HealthSpan Medicare Advantage Evidence of Coverage which is mailed to the Member’s home on an annual basis.

4.8.3 Outpatient Physical, Occupational and Speech Therapy Services
Outpatient therapy Services require Precertification for HealthSpan Medicare Advantage Members. Once an In-Network therapy Provider has been selected, fax a Care Management Department Referral Form (see Appendix F.1 of this HealthSpan Medicare Advantage Provider Manual) to the HealthSpan Care Management Department at 216-529-5530. If you need to speak with a Referral Specialist, call 866-433-1333 (toll-free).

The following information must appear on the Referral form or your request for therapy may be returned to your office unprocessed:

- Member name.
- Member Medical Record Number.
- Referring Physician’s name.
- Diagnosis with CPT Code.
- Onset & duration of symptoms.
- Treatment options given to the patient.
- Specify if this is work related.
- Indicate if this is related to a Motor Vehicle Accident.
- Describe the patient’s previous function.
- Explain the goals of therapy.
• Requested number of visits (6 usually recommended). Extensions will be granted according to Care Management Department criteria and protocols.
• Write the location of the therapy Provider on the Referral form.

To avoid a delay in care, give the Member a copy of the Referral form to take to their first therapy appointment. Members should wait to call for their first appointment until after they receive their Authorization letter from HealthSpan.

Plan therapy Providers must comply with HealthSpan’s Utilization Review requirements. For a current list of Plan therapy Providers, refer to the HealthSpan Provider Lookup website at northeastohio.healthspanproviders.org, or contact either your designated Provider Relations Department in Cleveland or Cincinnati or call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to request a HealthSpan Ancillary Provider directory.

Medicare Advantage Members may call the HealthSpan Customer Relations Department, 8 a.m. – 8 p.m. daily, 800-493-6004, to verify Covered Benefits and to determine what Copayments and exclusions may apply. The hearing/speech impaired may call 711 (toll-free TTY). Information regarding Covered Benefits also appears in the HealthSpan Medicare Advantage Evidence of Coverage which is mailed to the Member’s home on an annual basis.

4.9 Clinical Trials
HealthSpan covers Services Members receive in connection with a clinical trial if all of the following conditions are met:
• We would have covered the Services if they were not related to a clinical trial including Routine Patient Care.
• The Member is Eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted).
• For life-threatening conditions, other than cancer, a determination of eligibility is made in one of the following ways:
  • A Plan Provider makes this determination.
  • The Member provides us with medical and scientific information establishing this determination.
• With the exception of Eligible Cancer Clinical Trials, if any Plan Providers participate in the clinical trial and will accept a Member as a participant in the clinical trial, the Member must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where the Member lives.
• The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
  • The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
  • The study or investigation is a drug trial that is exempt from having an investigational new drug application.
  • The study or investigation is approved or funded by at least one of the following:
    • The National Institutes of Health.
    • The Centers for Disease Control and Prevention.
    • The Agency for Health Care Research and Quality.
    • The Centers for Medicare & Medicaid Services.
    • A cooperative group or center of any of the above entities or of the Department of Defense, the Department of Veterans Affairs.
    • A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    • The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines:
      • To be comparable to the National Institutes of Health system of peer review of studies and investigations.
      • To assure unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

Exclusions:
• The investigational Service.
• Services provided solely for data collection and analysis and that are not used in the Member’s direct clinical management.
• A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
Plan Providers may call the HealthSpan Customer Relations Department, Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at 800-441-9742, option 1, to verify Eligibility, Copayments, Covered Benefits and limitations.

4.10 Procedure for Authorization Notices
The referral Plan Provider, the Member, and the referring Plan Provider will receive written notification of Authorized Services which require out-of-network Referral or Precertification. Members are reminded to bring a copy of their approved Authorization notice to their appointments.

4.10.1 Out-of-network Referral Provider Guidelines
1. Place the copy of the Authorization notice in the Member’s chart.
2. Forward all work-up results to the referring Plan Provider with any other pertinent clinical information pertaining to the consultation. Call the referring Plan Provider if your findings are urgent.
3. If the referral Plan Provider determines that additional visits are Medically Necessary prior the end date of the Authorization, the referral Plan Provider’s office may submit a completed Referral form either by fax or CareLink to the Care Management Department to request additional visits. Attach clinical notes supporting the need for additional visits.

4.10.2 Referring Plan Provider Guidelines
1. Place the copy of the Authorization notice in the Member’s chart.
2. Review all referral Plan Provider reports and test results. Initial and date all reviewed documents.
3. Place all referral Plan Provider reports and test results in the Member’s chart.

4.11 Denied Authorizations
The following could be some of the reasons an out-of-network Referral or a Precertification request was denied:
- Services are deemed not Medically Necessary.
- The patient does not meet membership Eligibility requirements.
- The requested service is not a Covered Benefit or the Benefit is exhausted.
- Services were performed without prior Authorization.
- There is no reason to use an out-of-network Provider.
4.11.1 Denials for Inpatient Days for Hospitals, Skilled Nursing and Comprehensive Outpatient Rehabilitation Facilities, and Home Health Care

If Medical Management decides to deny services or payments, in whole or in part, or discontinues/reduces a previously authorized ongoing course of treatment, then it must give the Member a written notice of its Adverse Determination. The Medical Management department will fax the Member’s denial letter to the facility’s case management/utilization management department and will request that their facility’s case management/utilization management department immediately deliver the denial letter to the Member or the Member’s representative, in person. The facility’s representative is to ask the Member to sign and date the letter as proof of receipt. Once this is completed, the facility’s representative is to fax the signed, dated letter immediately back to the HealthSpan Care Management Department at 866-422-5940.

4.11.2 All Other Denials

The specific reason for the denial is stated in each notice of Adverse Determination sent to the Member and the referring Plan Provider. Adverse Determination letters will also inform the Member of his/her right to appeal the denial and the Plan Provider of his or her right to have the denial reconsidered. Reconsiderations are only offered for Medical Necessity denials.

All Appeal requests submitted by Plan Providers must be accompanied by a written appointment of the Plan Provider as the authorized representative of the Member. Plan Provider requests for retroactive Referrals are not accepted by the Care Management Department. If you feel an Adverse Determination has been issued in error, then, as the Authorized Representative of the Member, write the Appeals Unit to request an Appeal of the Adverse Determination. See pages 35 and 37 of this Manual for more information regarding policies and procedures for Members.

4.12 Reconsiderations and Appeals

Plan Providers have the right to request a Reconsideration of any Pre-Service Medical Necessity initial decision made by HealthSpan. Plan Providers are also afforded the opportunity to appeal any decision made by HealthSpan to deny reimbursement for Services already rendered by that Plan Provider as a Payment Dispute or as a Post-Service Claim when the Plan Provider is acting as the Member’s authorized representative. For information regarding the HealthSpan Plan Provider Reconsideration and Provider Appeal Guidelines and Processes, see page 35 and/or page 37 of this Manual. For information regarding Payment Disputes, see page 37 of this Manual.
4.12.1  Reconsideration of Decisions Following Initial Determination Denial
A Plan Provider has the right to request verbally or in writing on behalf of a Member (with the Member’s specific consent) a Reconsideration of a Pre-Service or Concurrent Adverse Determination issued in response to a request for an Authorization or Referral based on Medical Necessity.

NOTE: This process does not apply to Post-Service Claim payment denials. The Member’s written consent must be obtained prior to pursuing Reconsideration. See Appendix F.9 of this HealthSpan Medicare Advantage Provider Manual for a sample Appointment of Representative form.

Reconsiderations are conducted between the Plan Provider and the Physician Advisor who made the Adverse Determination. If the Physician Advisor cannot be available within 3 business days, the Physician Advisor may designate another Physician to review the Reconsideration. To request a Reconsideration, Plan Providers may call 866-433-1333 (toll-free) or fax your Reconsideration and the Appointment of Representative form to 866-329-6004 (toll-free).

Decisions on the Reconsideration are made within 3 business days after the receipt of the request for Reconsideration, unless the medical condition of the Member indicates a need for a more prompt decision. If the Reconsideration does not resolve the difference of opinion, Plan Providers may file a written Appeal as the Authorized Representative of the Member. See pages 35 and 37 of this Manual for Appeal guidelines and processes. The Reconsideration process is not a prerequisite to the Appeal process.

4.12.2  Standard Appeal Process of Initial Adverse Pre-Service Determinations
The following guidelines for Pre-Service Appeals apply to Services that are not urgent in nature:

- The requesting Plan Provider may submit a written Appeal request along with a signed Appointment of Representation (AOR) form (see Appendix F.9 of this HealthSpan Medicare Advantage Provider Manual) from the Member to the HealthSpan Appeals Unit at the following address:

    HealthSpan Appeals Unit
    P.O. Box 93764
    Cleveland, OH 44101-5764

    Or fax the Appeal with the AOR to: 216-635-4673.
NOTE: In the event the Service requested is urgently needed, the Plan Provider may request an expedited Appeal without the Member’s prior authorization by calling 888-479-5333 (toll-free) or 216-635-4664. Generally, a request for Services is urgent only if using the procedure for non-urgent Claims (a) could seriously jeopardize the patient’s life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of the patient’s medical condition, subject the patient to severe pain that cannot be adequately managed without the Services requested.

- In the event that a signed AOR form is not received with the Appeal request, the Member will be notified in writing and will be asked to complete the necessary AOR form, that authorizes the Plan Provider to act on the Member’s behalf.
- Appeal requests must be received within 60 calendar days of receipt of the initial Adverse Determination.
- The HealthSpan Appeals Unit staff will review the documentation and contact the appealing Plan Provider for additional information; if needed.
- The Appeal will be reviewed by either the Medical Advisory Council (MAC) for Medical Necessity denials or the Benefit Advisory Council (BAC) for benefit denials within 30 calendar days of receipt of the Appeal request. An appropriate Physician or Behavioral Health clinician makes all decisions for medical appropriateness. Physicians participating on the Medical Advisory Council shall not have been involved in the initial determination or be subordinates of a Physician involved in the initial determination.
- If the initial decision for a standard Pre-Service Appeal is overturned, the Appeals Unit staff will contact the Plan Provider and the Member in writing within 30 calendar days of the request, and will process the request.
- For HealthSpan Medicare Advantage Members: If the initial decision is upheld, the case will automatically be forwarded to the Independent Review Entity used by Medicare for the final determination.

4.12.3 Expedited Pre-Service Appeals
An expedited Appeal process is available for initial Adverse Determinations involving an urgent claim (request for services). A request is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize the patient’s life, health or ability to regain maximum function, or (b) could cause serious impairment of bodily function, organ or part, or (c) would, in the opinion of a physician with knowledge of the patient’s medical condition,
subject the patient to severe pain that cannot be adequately managed without
the Services requested.

- The requesting Plan Provider may fax a written Appeal request to the
  HealthSpan Appeals Unit at 216-635-4673 or call 888-479-5333 (toll-
  free) or 216-635-4664.
- The HealthSpan Appeals Unit staff will review the documentation and
  contact the appealing Plan Provider for additional information if needed.
- The Appeal will be reviewed by the Medical Advisory Council (MAC) as
  expeditiously as the patient’s clinical condition requires, but not to
  exceed 72 hours of the Appeal request. We may notify the Plan Provider
  of our decision orally, and we will send written confirmation within 3
days after that. An appropriate Physician or Behavioral Health clinician
  makes all decisions for medical appropriateness. Physicians participating
  on the Medical Advisory Council shall not have been involved in the
  initial determination or be subordinates of a Physician involved in the
  initial determination.
- If the initial decision for an expedited Pre-Service Appeal is overturned,
  the Appeals Unit staff will contact the Plan Provider and the Member
  verbally and in writing immediately following the determination.
- If the initial decision for an expedited Pre-Service Appeal is upheld for
  HealthSpan Medicare Advantage Members, the case is automatically
  forwarded to the Independent Review Entity used by Medicare for the
  final determination.

4.12.4 Plan Provider Post-Service Claim Appeals
Per Centers for Medicare & Medicaid guidelines, any party to an organization
determination (including a reopened and revised determination), i.e., a
Member, a Members representative or an out-of-network physician or provider
to the Medicare health plan may request that the determination be
reconsidered. However, In-Network Providers do not have Appeal rights.

4.13 Payment Disputes
Plan Providers may contact the HealthSpan Customer Relations Department
Monday through Thursday, 8:15 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m. at
800-441-9742, option 1, with questions or concerns about the way a particular
Claim was processed by HealthSpan. Many questions and issues regarding
Claim payments and/or denials can be resolved quickly over the phone or via
fax.
If, after contacting the Customer Relations Department, you are not in agreement with the answer or research outcome relative to your issue, you may file a formal Payment Dispute.

Following is the HealthSpan Provider Payment Dispute process for Medicare Advantage Claims:

1. Submit a formal Payment Dispute using the form in Appendix F.10 of this HealthSpan Care Medicare Advantage Provider Manual or a document of your own choosing that contains the information necessary to investigate your issue. Payment Dispute forms must be received within 60 calendar days of receipt of the initial Adverse Determination.

Send the Payment Dispute form and any supporting documentation to:

    HealthSpan
    Attention: Payment Dispute Unit
    P. O. Box 5316
    Cleveland, Ohio 44101

Or fax to: 216-227-4927.

2. Your Payment Dispute will be reviewed by a dedicated research specialist. Your rationale for request will be reviewed along with any additional information that you submit. All data available internally will also be considered in our research of your Claims payment or denial.

3. If the initial decision is overturned, the research specialist will process the Claim in dispute within 60 calendar days of receipt of the Payment Dispute form. Your Provider’s Explanation of Payment (EOP) will serve to notify you that the Claim has been paid.

4. If the initial decision is upheld, the research specialist will contact you in writing within 60 calendar days of receipt of the Payment Dispute form to inform you of the rationale for the decision.

NOTE: The Payment Dispute process is not intended for the purpose of filing an Appeal of a Pre-Service Claim or Post-Service Claim. This process is designed to provide a review of contract Payment Disputes, review of partially paid Claims, denials related to multiple procedures being performed on the same date where the Claim was not coded accordingly and other types of disputes which are contractual in nature based upon your status as a Plan Provider. See pages 35 and 36 of this Manual for more information regarding Pre-Service Appeals. See page 37 of this Manual for more information regarding Post-Service Claim Appeals.
The Payment Dispute process is not a prerequisite to the Appeal process. The Plan Provider can initiate an Appeal, in writing and on behalf of the Member, without going through the Payment Dispute process. Member’s written consent and authorization of you as his or her representative is required prior to pursuing an Appeal on the Member’s behalf. Contact the HealthSpan Appeals Unit at 888-479-5333 (toll-free) or 216-635-4664 to determine if a Member’s written consent is required.

4.14 Drug Formulary
See Section 10 of this HealthSpan Medicare Advantage Provider Manual for information regarding HealthSpan Formularies and pharmacy policy and procedures.

4.14.1 Requesting Coverage for Nonformulary Medications
See Section 10 of this HealthSpan Medicare Advantage Provider Manual for a complete description of Formulary policies and procedures, including Appeals.