

In-Network Provider Manual

Medicare Advantage



TABLE OF CONTENTS

ABOUT THIS MANUAL	8
MEDICARE ADVANTAGE PLANS OVERVIEW	8
KEY CONTACTS	9
MEMBER ELIGIBILITY VERIFICATION	12
CLAIMS SUBMISSION AND ERA/EFT	12
Claims Submission	12
Electronic claims submission	12
Paper claims submission	13
Electronic Remittance Advice and Electronic Funds Transfer	13
Transplants	13
Florida Custodial Care claims	14
Claims Submission	14
Timely Filing	14
Claims Format	14
Claims format standards	14
Offsetting	15
Claims Encounter Data	15
EOP and Remittance Advice	15
Prompt Payment	15
Pricing	15
ICD-10 DIAGNOSIS AND PROCEDURE CODE REPORTING	18
Billable Versus Nonbillable ICD-10 Codes	19
Questions Concerning ICD-10 and Claim Submission Guidelines	19
PROVIDER CLAIMS DISPUTE PROCESS AND APPEALS	19
Provider Claims Dispute Process	19
Submit an Appeal	20
Claim Disputes and Reconsiderations	21
COORDINATION OF BENEFITS	21
Terms and Definitions	22
Medicare Primary Versus Secondary Payer Responsibility	22
Basic Processing Guidelines for COB	23
When HealthSpring is the primary insurance:	23
When HealthSpring is the secondary insurance:	23
Workers' compensation	24
Subrogation	24
Medicaid COB	24

- Medicaid coverage groups 25
- VENDOR-SPECIFIC NETWORKS 26
- EVICORE BY EVERNORTH 26
 - High-tech radiology and diagnostic cardiology..... 26
 - Medical oncology (excludes Part D coverage) and radiation therapy 26
 - Musculoskeletal procedures..... 26
 - Durable medical equipment 27
- CLIA CERTIFICATION REQUIREMENT FOR LABORATORY SERVICES 27
- DME POS SUPPLIER ENROLLMENT REQUIREMENT..... 27
- CLINICAL REVIEW SERVICES 28
 - Overview..... 28
 - Utilization Management Requests 29
 - Prior Authorization 30
 - How to request prior authorization 31
 - Prior authorization forms 32
 - Prior authorization request time frames 32
 - Discharge Planning 34
 - Inpatient coordination of care and concurrent review..... 35
 - Adverse determinations – concurrent review 36
 - Retrospective review 38
 - Readmission quality program 38
 - Skilled nursing facility care and levels..... 39
 - Notice of Medicare Non-Coverage..... 42
- REFERRAL GUIDELINES..... 42
 - HMO Plans..... 42
 - PPO Plans 42
 - Plans That Require Referrals by State 43
 - How to Obtain a Referral..... 44
 - PCP Referral Responsibilities 45
 - Specialist Physician’s Referral Responsibilities 45
 - Referrals to Out-of-network Providers 45
- POPULATION HEALTH MANAGEMENT 45
 - Population Health Management Approach 45
 - How to Use Services 46
 - Provider contact information 46
 - Member information 46
 - Coordination with network providers..... 46
 - Continuity of care 47
- POPULATION HEALTH MANAGEMENT CLINICAL PROGRAMS 49

Benefits for you and your team	49
Benefits for your patients	49
To obtain support with vendor programs:.....	49
DRUGS/BIOLOGICS PART B (MEDICAL BENEFIT)	49
HealthSpring Medicare Advantage medical policy development and application.....	49
Prior Authorization	51
Step Therapy.....	52
OUTPATIENT OBSERVATION NOTICE.....	52
CREDENTIALING.....	52
Providers and Organizational Network Selection Criteria	52
Providers	52
Organizational provider.....	54
Credentialing and Recredentialing Process.....	55
Credentialing Committee and Peer Review.....	55
Provider Notification.....	56
Confidentiality of Credentialing Information	56
Nondiscrimination in the Decision-Making Process.....	56
PROVIDER INFORMATION, RIGHTS AND RESPONSIBILITIES	56
Access and Availability Standards for Providers	56
After-Hours Access Standards	57
Changes in Address or Other Practice Information	58
CMS demographic verification requirements	58
Plan notification requirements for providers.....	58
Communication Between Providers	59
A Provider's Role and Responsibilities	60
PCP's right to request member assignment to a different PCP (HMO only)	60
Medical Records	62
BEHAVIORAL HEALTH	62
Responsibilities of the PCP	62
Access to Care.....	63
Medical Record Documentation	63
Continuity of Care for Behavioral Health.....	63
Utilization Management for Behavioral Health	64
Contract Exclusions for Behavioral Health.....	64
PHARMACY.....	64
Pharmacy Prescription Benefit Part D Drug Formulary	64
A Part D drug is a drug that meets the following criteria:	64
Drugs excluded under Part D include the following:	65
Part D 100 Days' Supply	65

Part D Utilization Management	65
Coverage determination filing	66
Coverage determination outcome notification time frames	66
Information provided for denied and approved coverage determinations	66
Part D appeal outcome notification time frames	67
Part D appeals contact information:	67
Step therapy	67
Quantity limits	67
Pharmacy Quality Improvement	67
Medication therapy management program	68
Opioid drug management program	68
High-risk medication review programs	69
Clinical optimization pharmacist program	69
Population health: Pharmacy and medical integration program	69
Drug utilization review program	69
Pharmacy Stars Support Programs	70
Low-Income Subsidy Program	71
Pharmacy Networks	71
Preferred pharmacy network	72
PROVIDER COMMUNICATIONS AND MARKETING	72
MEMBER INFORMATION, RIGHTS AND RESPONSIBILITIES	75
Member Information	75
Member Rights	76
Member Responsibilities	79
Members are responsible for:	79
DELEGATION	80
ACCREDITATION	81
National Committee for Quality Assurance	81
Nondiscrimination and cultural competency	81
Additional provider rights and responsibilities	81
Provider responsibilities	82
PCPs are responsible for:	82
Specialists are responsible for:	82
All providers are responsible for:	82
Healthcare Effectiveness Data and Information Set (HEDIS)	83
QUALITY MANAGEMENT	83
Quality Improvement Program	83
Corporate Quality Improvement Committee	83
Values	84

Quality principles	84
Goals:	84
SPECIAL NEEDS PLANS	85
SNP Eligibility Criteria	86
SNP MOC Training.....	86
SNP MOC Process.....	86
SNP Interdisciplinary Care Team	87
SNP health risk assessment contact information	88
SNP scope.....	88
COMPLIANCE AND ETHICS	88
HealthSpring Corporate Compliance Program.....	88
To report suspected or detected Medicare Advantage plan noncompliance, contact:	89
Fraud, Waste and Abuse	89
HealthSpring Medicare Advantage Program Requirements.....	90
Books and Records: Governmental and Internal Audits and Inspections.....	91
Privacy and Confidentiality Safeguards.....	91
Patient Hold Harmless.....	91
APPENDIX.....	92
2026 Member ID Cards	92
SERVICE AREA MAPS	93
Alabama, North Florida and North and South Mississippi	93
Arizona	94
Arkansas	94
Colorado	95
Connecticut	95
Delaware.....	96
District of Columbia	97
Florida	98
Georgia.....	98
Illinois.....	99
Southern Illinois and St. Louis.....	99
Maryland.....	100
Kansas City	100
Missouri	101
New Mexico	102
Nevada	103
New York and New Jersey	103
North Carolina and South Carolina	105
Ohio and Kentucky	105

Oklahoma	107
Oregon	107
Pennsylvania	108
Tennessee	108

ABOUT THIS MANUAL

Thank you for participating in our Medicare Advantage network. This provider manual has been created to help you and your office staff administer plans for your patients with Medicare Advantage plan coverage through HealthSpring. It contains important information about our policies and procedures, including claims payments and submission requirements, and prior authorization and referral requirements. Please make time to review the manual carefully.

This manual serves as an extension of your network-participation agreement, with which all providers are required to comply. It replaces and supersedes all prior manual versions. To the extent there is any inconsistency between the terms of this manual and your network-participation agreement, the terms of your network-participation agreement will control.

MEDICARE ADVANTAGE PLANS OVERVIEW

This manual will guide you through the differences between our health maintenance organization (HMO) and preferred provider organization (PPO) plans.

The table below outlines things you need to know as you navigate through this manual.

Topic	What you need to know
Referrals	<ul style="list-style-type: none"> HMO: Referrals are required in select plans. See the Plans that Require Referrals by State section to determine which markets require referrals. PPO: Referrals are not required. However, before receiving services from providers who do not participate in our Medicare Advantage network, the member may want to ask for a previsit coverage determination.
Local network information	<ul style="list-style-type: none"> Regional service-area maps are in the Appendix. Market-specific contacts are located throughout this manual depending on the topic. See 2026 Member ID Cards in the Appendix for high-level product and network information. Refer to the phone numbers on the ID card for assistance, and follow guidance for eligibility verification, referrals and prior authorizations.

HealthSpring contracts with the Centers for Medicare & Medicaid Services to offer Medicare Advantage plans. Members are able to select one of several plans offered based on their location, budget and health care needs.

Plan type	Selection of a primary care provider	Referrals to specialists	HealthSpring ID card
HMO	Members are: <ul style="list-style-type: none"> Required to select a PCP Allowed to select a different PCP at any time 	See Plans that Require Referrals by State	The member's plan type is indicated at the top of their HealthSpring ID card. See the 2026 Member ID Cards in the Appendix.
PPO	<ul style="list-style-type: none"> Referral requirements are indicated on the member's HealthSpring ID card. Select service areas do not require the use of referrals. 	Not required	

KEY CONTACTS

Availity® Essentials self-service portal	
Availity Essentials If you aren't yet registered for Availity Essentials, sign up at no cost . Payer ID: 52192	
Provider Customer Service	
1-800-230-6138, 7 a.m. to 8 p.m. CT, Monday-Friday	
Provider directory	
Learn how to review and update your information at HealthSpring.com/Providers .	
Claims processing	
Claims questions: 1-800-230-6138	
Electronic claims: HealthSpring – Payer ID 52192	
Paper claims HealthSpring PO Box 23456 Chattanooga, TN 37421	
Medical necessity claim disputes HealthSpring Appeals PO Box 188085 Chattanooga, TN 37422	
Reconsideration requests HealthSpring Reconsiderations PO Box 20002 Nashville, TN 37202	
Coding and documentation	
Coding and documentation resources are on HealthSpring.com/Providers	
Copayment information and eligibility verification	
Phone: 800-668-3813 Provider self-service portal: Availity Essentials	
Compliance	
Report by phone Call: 855-249-6524 This toll-free Fraud Hotline is available 24 hours a day, seven days a week. You can remain anonymous or let us know if you want to be contacted.	Report by mail HealthSpring Special Investigations Department 300 E. Randolph St., 35 th floor Chicago, IL 60601
Credentialing	
Council for Affordable Quality Healthcare: Proview.CAQH.org	

Part C appeals	
Appeals questions: <ul style="list-style-type: none"> • Call 1-800-511-6943 • Fax 1-800-931-0149 Mail or fax standard medical appeals to: HealthSpring Medicare Advantage Appeals PO Box 188081 Chattanooga, TN 37422 Fax: 855-350-8671	Mail or fax expedited medical appeals to: HealthSpring Medicare Advantage Appeals PO Box 188082 Chattanooga, TN 37422 Fax: 855-350-8672 Mail or fax postservice in-network provider appeals to: HealthSpring Medicare Advantage Appeals PO Box 188085 Chattanooga, TN 37422 Fax: 855-699-8985
Prior authorizations	
Access our interactive prior authorization requirements at HealthSpring.com/Providers . To search our prior authorization guide for a code, enter Ctrl+F > the five-digit code.	
To submit a prior authorization request <ul style="list-style-type: none"> • Log in to Availity Essentials and access the prior authorization portal in the HealthSpring Medicare Advantage payer space. • Call Prior authorization: 1-800-453-4464 Part B: 1-888-454-0013 • Fax Prior authorization: 1-866-287-5834 Part B: 1-877-730-3858 	
EviCore	
eviCore prior authorization by service line	eviCore website or call for the service lines listed below eviCore Clinical Guidelines Web portal support Email Call 1-800-646-0418 (option 2) Non-prior authorization inquiries Email Call 1-800-575-4517 (option 3)
High-technology, radiology and diagnostic cardiology	Clinical support and program inquiries Email Call 1-888-693-3211 Fax 1-888-693-3210
Medical oncology and radiation therapy	Medical oncology Call 1-866-668-9250

	<p>Fax 1-800-540-2406</p> <p>Radiation therapy Call 1-866-686-4452 Fax 1-866-699-8128</p>
Musculoskeletal procedures	<p>Call 1-888-693-3297 Fax 1-888-693-3210</p>
Patient support programs	
<p>To evaluate patient eligibility, refer to HealthSpring.com/Providers.</p> <p>To learn more about a program or request a patient eligibility evaluation, email us.</p>	
Pharmacy	
<p>Pharmacy Part D prior authorization requests</p> <ul style="list-style-type: none"> • Visit CoverMyMeds • Call 1-877-813-5595 • Fax 1-866-845-7267 <p>Express Scripts Pharmacy Call 1-800-211-1456</p> <p>Home delivery pharmacy Call 1-800-285-4812</p> <p>Medicare Advantage drug list formulary HealthSpring.com/Providers</p> <p>Accredo Provider service center: 1-844-516-3319 Accredo prescribers</p> <p>Accredo specialty medication list HealthSpring.com/Providers</p>	
Referrals	
<p>HMO referrals vary by plan. PPO plan referrals are not required.</p> <p>Obtain referrals for specialists at Avality Essentials. Access the prior authorization portal through the HealthSpring Medicare Advantage payer space.</p>	
Supplemental benefits and ancillary services	
<p>Outpatient laboratory services</p> <ul style="list-style-type: none"> • LabCorp Call 1-888-522-2677 • Quest Diagnostics laboratories Call 1-866-697-8378 <p>Behavioral health substance use disorder</p>	<p>Dental allowance questions Phone: 866-213-7295 DHMO plans: All providers (except Arizona) Phone: 866-213-7295</p> <p>Claims mailing address: HealthSpring Dental PO Box 188037 Chattanooga, TN 37422-8037</p>

(authorizations) Call 1-866-780-8546 Fax 1-866-949-4846	Arizona providers only Phone: 800-367-7037
For questions about supplemental benefits, call Provider Customer Service at 1-800-230-6138.	

MEMBER ELIGIBILITY VERIFICATION

All in-network providers are responsible for verifying a member’s eligibility for each visit. You can call HealthSpring or visit [Availity Essentials](#) to verify eligibility when the member cannot present identification or does not appear on your monthly eligibility list.

Please note that while HealthSpring will have the most up-to-date information available, member data is subject to change; CMS can retroactively terminate members for various reasons that can retroactively affect their eligibility. If HealthSpring pays a claim that is then retroactively terminated, our claim recovery unit will request a refund from the provider or offset the overpayment. The provider must then contact CMS Eligibility to determine the member’s actual benefit coverage for the date of service in question.

The table below outlines methods to verify member eligibility.

Method	Contact/resource information
Provider Customer Service	1-800-230-6138, 7 a.m. to 8 p.m. CT, Monday-Friday
Provider self-service portal	Availity Essentials
HealthSpring ID card	Review the member’s HealthSpring ID card to determine the following: <ul style="list-style-type: none"> • Plan code • Copayment • Effective date See the Appendix: 2026 HealthSpring Member ID Cards.

CLAIMS SUBMISSION AND ERA/EFT

HealthSpring prefers electronic submission of claims. However, both electronic and paper claims are accepted. Refer to Key Contacts for information about Part C appeals, reconsideration requests and claims questions. If you are interested in submitting claims electronically via electronic data interchange, call Provider Customer Service at **800-230-6138**.

Claims Submission

Electronic claims submission

Claims may be submitted electronically using **payer ID 52192**.

Paper claims submission

Paper claims

HealthSpring
PO Box 23456
Chattanooga, TN 37421

Supporting claim documentation

Send supporting claims documents – such as medical records, itemized bills and explanation of benefits – via fax to **615-401-4642** or mail them to:

HealthSpring Claims Intake
PO Box 20002
Nashville, TN 37228

Electronic Remittance Advice and Electronic Funds Transfer

ERA and EFT enrollment

You may enroll in ERA and EFT on the Zelis website. Visit <https://healthspring.epayment.center/> for more information.

ERA and EFT post-enrollment support

After enrolling in ERA and EFT, call 833-306-0337 if you need assistance.

Transplants

HealthSpring has a specialized team of registered nurses who provide a unique care experience for members involved in the transplant process. Each member who is undergoing transplant services is assigned a nurse who is dedicated to providing case management, utilization management, provider coordination and transplant resources.

Members are enrolled in this program from the time the provider requests evaluation authorization until after the member receives their transplant or until the provider has deemed the member is not a candidate for transplant.

The transplant team services members receiving one or more of the following therapies:

- Solid organ transplant
- Ventricular assist devices and total artificial hearts
- Autologous bone marrow transplant and stem cell transplant
- Allogeneic bone marrow transplant and stem cell transplant
- Chimeric antigen receptor T-cell therapy

To initiate an authorization request, fax the request to **866-287-5834**.

To access the transplant prior authorization request form, go to HealthSpring.com/Providers.

Claims processing

For organ acquisition cost reimbursement, providers must submit a clean claim to HealthSpring, along with a copy

of the most recent CMS cost report worksheet referenced as CMS-2552-10, Worksheet D-4.

Kidney acquisition costs are not reimbursed by HealthSpring and are instead paid by CMS for all Medicare Advantage enrollees.

For hematopoietic stem cell transplants acquisition cost reimbursement, submit a clean claim to HealthSpring, along with a copy of the most recent CMS cost report worksheet, referenced as CMS-2552-10, Worksheet D-6.

Florida Custodial Care claims

Florida providers must request prior authorization when a Dual Eligible Special Needs Plan (D-SNP) member requires admission to a nursing facility.

Claims Submission

Claims can be submitted electronically or by mail within 180 days from the initial date of service. Providers should follow their contract or provider manual time frames.

Timely Filing

As a HealthSpring in-network provider, you have agreed to submit all claims within the time frames outlined in your provider agreement.

Claims Format

The standard CMS-required forms and data elements can be found in the CMS claims processing manual on [CMS.gov](#) > Manuals > Internet Only Manuals > 100-04 > [Chapter 12 – Physicians/Nonphysician Practitioners](#). Appropriate forms and data elements must be present for a claim to be considered a clean claim.

HealthSpring can only pay claims that are submitted accurately. The provider is always responsible for accurate claims submissions. While HealthSpring will attempt to inform the provider of claims errors, responsibility for claim accuracy rests solely with the provider.

Physicians in the same group practice and in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same member by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service that is representative of the combined visits and submit the appropriate code for that level.

Physicians who are in the same group practice, but in different specialties, may bill and be paid separately if they perform a service on the same day to the same to the same member in the same group.

Claims format standards

HealthSpring pays clean claims according to contractual requirements and CMS guidelines. A clean claim is defined as a claim for a covered service that has no defect or impropriety and otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare.

A defect or impropriety includes, without limitation, lack of data fields required by HealthSpring or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of

HealthSpring, the claim is not considered clean.

Claims Review

The HealthSpring review of claims may result in payments being classified as overpayments. The review includes, but is not limited to, itemized bills, clinical records or notes (collectively “records”). If requested by HealthSpring or our designee, providers must submit requested records within 30 days for HealthSpring to accurately adjudicate all claims in a timely manner.

Offsetting

Providers that participate in the HealthSpring network will be informed of any overpayments or other payments owed to us. They will have at least 30 days (based on specific contract language) from receipt of the repayment request to refund the amount owed. We will provide:

- The patient’s name
- Identification number
- HealthSpring claim number
- Your member account number
- Date of service
- A brief explanation of the recovery request
- The amount owed

If we do not receive the requested amount owed within 30 days, we will offset the amounts identified in the initial repayment request or in accordance with the terms of your agreement, unless we receive an appeal. In addition, any CMS fee schedule or pricing changes will be applied and effective on the date specified by CMS. Evidence of such adjustments shall be included in the explanation of payment or remittance advice.

Claims Encounter Data

Providers who are paid under capitation agreements must submit claims to capture encounter data as required according to their HealthSpring provider agreement.

EOP and Remittance Advice

An EOP and remittance advice are sent to providers after coverage and payment have been determined by HealthSpring. The statement provides a detailed description of how the claim was processed.

Prompt Payment

HealthSpring will pay participating providers in accord with the applicable provisions of their agreement with HealthSpring.

Pricing

Overview

Original Medicare typically has market-adjusted prices by code – such as by Current Procedural Terminology (CPT[®]) code or Healthcare Common Procedure Coding System code – for services that Original Medicare covers. However, there are occasions where HealthSpring offers a covered benefit for which Medicare has no pricing. To expedite claims processing and payment in these situations, HealthSpring will determine the price by researching

other external publicly available pricing sources, such as other payers, fiscal intermediaries or state-published schedules for Medicaid.

We request that you make every effort to submit claims with standard coding; failure to do so could delay processing. As described in this manual and/or your agreement, you retain the right to submit a claim dispute or reconsideration request if you feel the reimbursement was incorrect. In the instance of an inpatient admission downgrade to observation, submit an itemized bill that includes CPT and/or HCPCS codes to expedite processing.

Chronic care management and advanced primary care management

HealthSpring will not reimburse providers for chronic care management or advanced primary care management services, as defined by CMS. By way of example and without limitation, these services currently include CPT codes 99490, 99491, 99439, 99437, 99487, 99489, G0556, G0557 and G0558.

Pricing of inpatient claims

Unless your contract states otherwise, all outpatient services (including observation and emergency room services) furnished to a member by a hospital during an uninterrupted encounter (no discharge home) on the date of a member's inpatient admission or immediately preceding the date of their inpatient hospital admission, regardless of the number of uninterrupted days prior to the inpatient admission, will be paid under the applicable inpatient Medicare Severity Diagnosis Related Group (MS-DRG).

Skilled nursing facility consolidated billing

HealthSpring pays for the majority of services provided to members in a Medicare-covered Part A skilled nursing facility stay — including most services provided by entities other than the SNF — in a bundled prospective payment to the SNF. The SNF must bill these bundled services in a consolidated bill. For services subject to consolidated billing and provided by entities other than the SNF, the entities will look to the SNF for payment and must not bill separately for those services.

Consolidated billing resources

For more information, take the SNF Consolidated Billing [training](#) on the Medicare Learning Network® Learning Management and Product Ordering System. Go to [CMS.gov](#) > Training & Education > Medicare Learning Network (MLN): Resources & training > Web-Based Training > [SNF Consolidated Billing](#).

To help determine how consolidated billing applies to specific services, refer to the flowcharts in the Skilled Nursing Facility Prospective Payment System processing of hospice claims. Go to [CMS.gov](#) > Medicare > Payment: All Fee-for-Service Providers > [Skilled Nursing Facility PPS](#).

Rate letters from A/B MAC – Critical access hospitals and rural health clinics

Providers must provide a copy of their most recent interim rate letter from their A/B Medicare Administrative Contractor (MAC) to HealthSpring, and to forward to HealthSpring any changes or adjustments to such per diems or rates as soon as possible, but no later than 30 days following CMS' notification to each individual facility regarding any changes or adjustment to such rates.

HealthSpring will not retroactively adjust undercompensation unless otherwise indicated in the provider contract. If HealthSpring has not received an updated rate letter from the provider in more than 12 months, claims may be denied.

Rate letters should be submitted via email to PDM@Healthspring.com.

Service group descriptions

These descriptions serve as a reference to outline the services included under each contract group. This does not provide any details regarding coverage of services. Refer to the current CMS guidelines and HealthSpring medical policies for information on coverage of services.

Primary Care Physician Services (excluding categories below): MD or DO

- Family Medicine, Internal Medicine, Geriatric Medicine

Specialist Physician Services (excluding categories below): MD or DO

- Excluding: Family Medicine, Internal Medicine, Geriatric Medicine

Nurse Practitioner/Physician Assistant Services (excluding categories below): NP, PA

Durable Medical Equipment, Prosthetics, Orthotics and Supplies:

- All CPT codes included on CMS DMEPOS Fee Schedules
- A2000 - A9999, E0100 - E3200, K0001 - K1037, L0100 - L9900, Q0477 - Q0509, Q1004 - Q1005, Q4001 - Q4051, V2020 - V2799

Lab Services:

- Venipuncture, Pathology
- All CPT codes included on CMS Clinical Laboratory Fee Schedule
- 80000 - 89999

Radiology Services:

- 70000 - 79999, G0279, G6001 - G6017
- Imaging, high-tech imaging, radiation therapy

Physical Therapy/Occupational Therapy/Speech Therapy Services: PT, OT, SLP, SP

Part B Drugs and Biologicals:

- CPT codes in CMS ASP Pricing Files

Hospice claims

A Medicare Advantage enrollee who elects hospice care, but chooses not to disenroll from the plan, is entitled to continue to receive through the plan any Medicare Advantage benefits other than those that are the responsibility of the hospice. Under such circumstances, the Medicare Advantage plan is paid a reduced capitation rate for that enrollee by CMS and the Medicare Advantage plan is responsible for continued coverage of supplemental benefits. CMS pays: (a) the hospice program for hospice care furnished to the enrollee and (b) the Medicare Advantage plan, providers and suppliers for other Medicare-covered services furnished to the enrollee through the Original Medicare program, subject to the usual rules of payment.

Hospice coverage is effective immediately on the date of election; the reduced rate paid to the Medicare Advantage plan begins the next month (42 C.F.R. § 422.320).

Table I below summarizes the cost sharing and provider payments for services furnished to a Medicare Advantage

plan enrollee who elects hospice.

Table I: Payments for services furnished to an enrollee who has elected hospice

Type of services	Enrollee coverage choice	Enrollee cost share	Payments to providers
Hospice program	Hospice program	Original Medicare cost share	Original Medicare
Non-hospice care, Parts A and B	Medicare Advantage plan or Original Medicare	Medicare Advantage plan cost share, if enrollee follows Medicare Advantage plan rules	Original Medicare
		Original Medicare cost share, if enrollee does not follow Medicare Advantage plan rules	Original Medicare
Non-hospice care, Part D	Medicare Advantage plan (if applicable)	Medicare Advantage plan cost share	Medicare Advantage Organization (MAO)
Supplemental	Medicare Advantage plan	Medicare Advantage plan cost share	MAO

Please see the following resources for additional information:

- The Social Security Act, section 1853(h)(2)(B); and
- The Medicare Claims Processing Manual, chapter 11 – Processing Hospice Claims, section 30.4

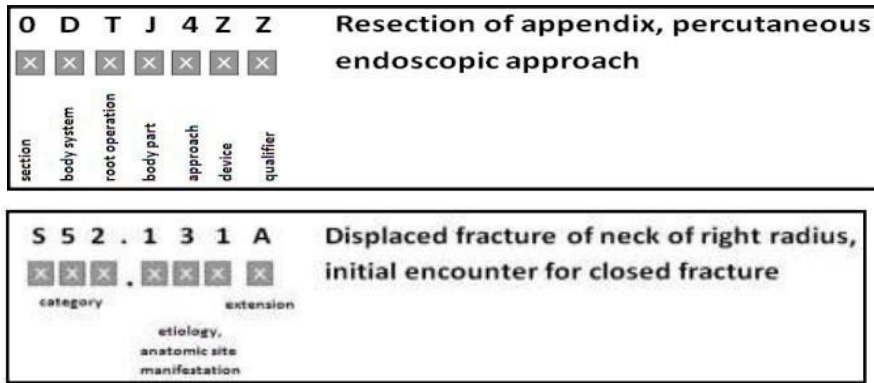
ICD-10 DIAGNOSIS AND PROCEDURE CODE REPORTING

In January 2009, the U.S. Department of Health and Human Services published a final rule requiring the use of International Classification of Diseases, 10th Revision (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors and other health care professionals, as well as vendors and trading partners. Providers must be diligent about confirming the accuracy of their diagnoses and ensure that their diagnoses and coding practices comply with all applicable legal requirements.

ICD-10 consists of two parts:

1. ICD-10-Clinical Modification (CM) for diagnosis coding is for use in all U.S. health care settings. It uses three to seven characters instead of the three to five characters that were used with ICD-9-CM, adding more specificity.
2. ICD-10-Procedure Coding System (PCS) for inpatient procedure coding is for use only in U.S. inpatient hospital settings. It uses seven alphanumeric characters instead of the three or four numeric characters that were used with ICD-9-CM, adding more specificity and making them substantially different.

Note: Procedure codes are only applicable to inpatient claims and not prior authorizations.



ICD-10 compliance applies to diagnosis and inpatient procedure codes for all entities covered under the Health Information Portability and Accountability Act, not just those who submit Medicare or Medicaid claims.

Billable Versus Nonbillable ICD-10 Codes

- A billable ICD-10 code is defined as a code that has been coded to its highest level of specificity.
- A non-billable ICD-10 code is defined as a code that has not been coded to its highest level of specificity. A claim submitted with a nonbillable code will be rejected.

Example: Billable ICD-10 code with corresponding nonbillable codes.

Billable ICD-10 codes	Nonbillable ICD-10 codes
M1A.3110 – Chronic gout due to renal impairment, right shoulder, without tophus	M1A.3 – Chronic gout due to renal impairment M1A.311 – Chronic gout due to renal impairment, right shoulder

It is acceptable to submit a claim using an unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.

Questions Concerning ICD-10 and Claim Submission Guidelines

If you believe any codes were previously submitted in error (for example, the patient never had the condition listed), contact your Provider Education Specialist. Provide the patient’s name, date of service and diagnosis code so that the code can be researched and retracted, if appropriate.

Go to [HealthSpring.com/Providers](https://www.healthspring.com/providers) to access documentation and coding resources.

PROVIDER CLAIMS DISPUTE PROCESS AND APPEALS

Provider Claims Dispute Process

An appeal is a request for HealthSpring to review a previously made decision related to medical necessity, clinical guidelines or prior authorization and referral requirements. HealthSpring offers participating providers one level

of appeal. The following should be considered when requesting an appeal:

- You must receive a notice of denial or remittance advice before you can submit an appeal.
- Do not submit your initial claim in the form of an appeal.
- An appeal must be submitted within 65 days of the original decision unless otherwise stated in your provider agreement.
- With your appeal request, you must include an explanation of what you are appealing along with the rationale for appealing, a copy of your denial, any medical records that would support the medical necessity for the service, hospital stay or office visit, and a copy of the insurance verification completed on the date of service. If necessary medical records are not submitted, the request will be returned without action until the medical records are submitted. They must be received within the time frame for which the provider must submit their request for appeal.
- Appeals can take up to 60 days for review and determination.
- Timely filing requirements are not affected or changed by the appeal process or by the appeal outcome.
- If an appeal decision results in approval of payment contingent on the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in your HealthSpring agreement.
- You may appeal a previous decision not to pay for a service. For example, you may appeal claims denied for no prior authorization or no referral, including a decision to pay for a different level of care. This includes both complete and partial denials. Examples of partial denials include denials of certain levels of care, isolated claim line items not related to claims reconsideration issues, or a decreased quantity of office or therapy visits not related to claims reconsideration issues.
- Total and partial denials of payment may be appealed using the same appeal process.

Your appeal will receive an independent review by a HealthSpring representative not involved with the initial decision.

- Requesting an appeal does not guarantee that your request will be approved or that the initial decision will be overturned. The appeal determination may fully or partially uphold the original decision.
- You may appeal a health services or utilization management denial of a service not yet provided on behalf of a member. The member must be aware that you are appealing on their behalf. This may be done through an Appointment of Representative Form.

Submit an Appeal

Complete the postservice appeal and claim dispute form on the HealthSpring website and submit by fax or mail:

Fax

Participating provider appeals: 855-699-8985

Mail

HealthSpring Appeals
PO Box 188085
Chattanooga, TN 37422

If you have questions on appealing or disputing a claim, call 800-511-6943.

Be sure to attach medical records and submit your appeal in one of the following ways:

- Via secure email to FAX-SOL@HealthSpring.com, or
- Fax based on the appeal type in the table below.

For large medical record files, you may mail or email the appeal request form with a CD attachment containing medical records.

Appeal type	Mailing address	Fax number
Medical appeals standard	PO Box 188081 Chattanooga, TN 37422	855-350-8671
Medical appeals expedited	PO Box 188082 Chattanooga, TN 37422	855-350-8672
Part C Independent Review Entity	PO Box 188083 Chattanooga, TN 37422	855-594-4423
Fast track appeals (Quality Improvement Organization)	PO Box 188084 Chattanooga, TN 37422	855-594-4432
Participating provider appeals (post-service)	PO Box 188085 Chattanooga, TN 37422	855-699-8985
Provider payment disputes (HMO only)	HealthSpring Attn: Provider Payment Disputes PO Box 1004 Nashville, TN 37202	860-731-3463

Claim Disputes and Reconsiderations

You have up to 180 days from the claim payment date to request a reconsideration. You may request a claim reconsideration if you feel your claim was not processed appropriately according to the HealthSpring claim payment policy or in accordance with your provider agreement. A claim dispute/reconsideration request is appropriate for disputing denials such as matters concerning coordination of benefits, timely filing or missing information.

Payment retractions, underpayments, overpayments and coding disputes should also be addressed through the claim dispute or reconsideration process. HealthSpring will review your request, as well as your provider record, to determine whether your claim was paid correctly.

COORDINATION OF BENEFITS

Coordination of benefits is the process of determining and reconciling a payer's responsibility for reimbursement when a member is eligible for benefits under more than one insurance company or other payer type (e.g., Medicare and Medicaid). Terms and conditions within the summary of benefits for each plan will generally dictate which payer is primary, secondary or tertiary and any mathematical formula associated for calculating each pay portion of coverage.

Coordinating payment of these plans will provide benefit coverage of up to but not exceeding 100 percent of the allowable amount. The respective primary and secondary payer obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners COB Model Regulations Guidelines.

Terms and Definitions

Term	Definition
Allowable expense	Any expense that is customary or necessary for health care services provided and covered by the member's health care plan.
Conclusion	COB applies the NAIC rules to determine which plan is primary, secondary or tertiary when alternate insurance coverage exists. All plans must adhere to the structure set forth in the Model COB regulations. Medicare Secondary Payer provisions apply for Medicare members under certain conditions.
Order of Benefit Determination Rule	When applied to a particular member covered by at least two plans, this rule determines the order of responsibility each plan has with respect to the other plan in providing benefits for the member. By applying the NAIC rules, it will be determined if a plan will have primary, secondary or tertiary responsibility for a person's coverage with respect to other plans.
Medicare Secondary Payer	MSP refers to situations where Medicare does not have primary payment responsibility. Specifically, Medicare pays second, and another entity or insurance company has responsibility to pay before Medicare.
Primary	The primary payer is responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists.
Secondary	The secondary payer is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment, not to exceed the total amount billed (maintenance of benefits).
Tertiary	The tertiary payer would come into effect only after the primary and secondary benefits are exhausted.

Medicare Primary Versus Secondary Payer Responsibility

The following list identifies some common situations when Medicare and other health insurance or coverage may be present, and which entity will be the primary or secondary payer.

If the member is:	And the below condition exists	The below program pays first	The below program pays second
Age 65 or older and covered by a group health plan through current employment or a family member's current employment	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more employees.	The group health plan pays primary	HealthSpring/ Medicare pays secondary
Age 65 or older and covered by a group health plan through current employment or a family member's	The employer has less than 20 employees.	HealthSpring/ Medicare pays primary	Group health plan pays secondary

current employment			
Entitled based on disability and is covered by a large group health plan through their current employment or through a family member's current employment	The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees.	The large group health plan pays primary	HealthSpring/ Medicare pays secondary
Entitled based on disability and is covered by a large group health plan through their current employment or through a family member's current employment	The employer employs less than 100 employees.	HealthSpring/ Medicare pays primary	Large group health plan pays secondary
Age 65 or older or entitled based on disability and has retirement insurance only	(The number of employees does not matter.)	HealthSpring/ Medicare pays primary	Retirement insurance pays secondary
Age 65 or older or is entitled based on disability and has Consolidated Omnibus Budget Reconciliation Act coverage	(The number of employees does not matter.)	HealthSpring/ Medicare pays primary	COBRA pays secondary

Basic Processing Guidelines for COB

For HealthSpring to be responsible as either the primary or secondary payer, the member must follow all HMO and PPO rules (e.g., pay copayments and follow appropriate referral process as applicable).

When HealthSpring is the primary insurance:

- Collect the copayment required under the member's Medicare Advantage plan with HealthSpring.
- Submit the claim to HealthSpring first.
- Be sure to have your patient sign the assignment of benefits sections of the claim form.
- Submit a copy of the claim with the remittance advice to the secondary payer for adjudication once payment or a remittance advice has been received from HealthSpring.
- HealthSpring Medicare Advantage is a total replacement for Medicare. Medicare cannot be a secondary payer when members have HealthSpring Medicare Advantage plans.
- Medicaid will not pay the copayment for HealthSpring members.

When HealthSpring is the secondary insurance:

- All HealthSpring guidelines must be met to reimburse the provider (e.g., prior authorization and referral forms).
- Collect only the copayments required.
- Be sure to have your patient sign the assignment of benefits sections of the claim form. Once you receive payment or the EOP from the other payers, submit to HealthSpring another copy of the claim with the EOP for reimbursement. Note all authorization numbers on the claims and attach a copy of the referral form, if applicable.

Workers' compensation

HealthSpring does not cover workers' compensation claims. When a provider identifies medical treatment as related to an on-the-job illness or injury, HealthSpring must be notified. The provider will bill the workers' compensation payer for all services rendered, not HealthSpring.

Subrogation

Subrogation is the substitution of one party in place of another with respect to a legal claim. In the case of a health plan that has paid benefits for its insured, the health plan is substituted in place of its insured. The health plan can make legal claims against the party that should be responsible for paying those bills – for example, the person who caused the insured's injuries and their third-party payer (e.g., property and casualty insurance, automobile insurance or workers' compensation payer).

The Basic Processing Guidelines for COB will still apply in the filing of the claim. HealthSpring may pay conditionally, subject to later recovery if there is a subsequent payment, settlement or judgment award from the liable party. Patients who may be covered by third-party liability insurance should only be charged the required copayment.

The bill should be submitted to the liability payer. The provider should submit the claim to HealthSpring with any information regarding the third-party payer (e.g., auto insurance name, lawyer's name). All claims will be processed in accordance with the usual claim procedures.

HealthSpring uses contracted vendors for review and investigation of all possible subrogation cases. The vendors coordinate all requests for information from the member, provider and attorney name(s) and office(s), and assists with settlements.

If you have questions related to a subrogated case, call customer service at **855-744-0223**. An experienced subrogation representative from our vendor, The Rawlings Group, will provide assistance.

Medicaid COB

Many members may have HealthSpring Medicare Advantage as their primary insurance and Medicaid as their secondary insurance. You must coordinate the benefits of these dual eligible HealthSpring members by determining whether they should be billed for the deductibles, copayments or coinsurances associated with their benefit plan. Providers may not assess a Qualified Medicare Beneficiary or QMB-Plus individual for HealthSpring copayments, coinsurances and/or deductibles. Medicaid is the payer of last resort when dual eligibility applies.

Providers can accept the HealthSpring payment as payment in full or seek additional payment from the appropriate state source. Additional information concerning Medicaid provider participation is available at state-specific Medicaid websites.

Providers are prohibited from billing, charging, collecting a deposit, seeking compensation or remuneration from, or having any recourse against any HealthSpring member for fees that are the responsibility of HealthSpring.

You can verify your patients' Medicaid eligibility using the Medicaid Eligibility Verification System. If you do not have access to the system, contact your state Medicaid agency for additional information.

Each state varies in their decision to cover the cost-share for populations beyond QMB and QMB-Plus.

Medicaid coverage groups

Qualified Medicare Beneficiary (QMB Only)

A QMB is an individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the Federal Poverty Level, and whose resources do not exceed three times the Supplemental Security Income limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance and copayments (except for Part D). QMBs who do not qualify for any additional Medicaid benefits are called "QMB Only." Providers may not assess a QMB for HealthSpring deductibles, copayments or coinsurances.

Qualified Medicare Beneficiary Plus (QMB+)

A QMB+ is an individual who meets standards for QMB eligibility and also meets criteria for full Medicaid benefits in the state. These individuals often qualify for full Medicaid benefits by meeting the Medically Needy standard or through spending down excess income to the Medically Needy level.

Specified Low-Income Medicare Beneficiary (SLMB Only)

An SLMB is an individual who is entitled to Medicare Part A, has income that exceeds 100 percent FPL but is less than 120 percent FPL, and whose resources do not exceed three times the SSI limit. The only Medicaid benefit for which an SLMB is eligible is payment of Medicare Part B premiums. SLMBs who do not qualify for any additional Medicaid benefits are called "SLMB Only."

Specified Low-Income Medicare Beneficiary Plus (SLMB+)

An SLMB+ is an individual who meets the standards for SLMB eligibility, but who also meets the criteria for full state Medicaid benefits. Such individuals are entitled to payment of the Medicare Part B premium, as well as full state Medicaid benefits. These individuals often qualify for Medicaid by meeting the Medically Needy standards or through spending down excess income to the Medically Needy level.

Qualifying Individual (QI)

A "QI" is an individual who is entitled to Medicare Part A, has income that is at least 120 percent FPL but less than 135 percent FPL, has resources that do not exceed three times the SSI limit, and is not otherwise eligible for Medicaid. A QI is similar to an SLMB in that the only benefit available is Medicaid payment of the Medicare Part B premium; however, expenditures for QIs are 100 percent federally funded and the total expenditures are limited by statute. QIs are not otherwise eligible for full Medicare coverage.

Other Full Benefit Dual Eligible (FBDE)

An FBDE is an individual who is eligible for Medicaid either categorically or through optional coverage groups – such as Medically Needy or special income levels for institutionalized or home and community-based waivers – but does not meet the income or resource criteria for QMB or SLMB.

Qualified Disabled and Working Individual (QDWI)

A QDWI is an individual who lost Medicare Part A benefits due to returning to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200 percent FPL and resources may not exceed twice the SSI limit. QDWIs are only eligible for Medicare.

VENDOR-SPECIFIC NETWORKS

HealthSpring may elect to offer or obtain certain covered services exclusively through arrangements with national or regional vendor networks. It is important for participating providers to be aware of these vendor-specific networks to avoid potential claims issues and member confusion.

HealthSpring currently utilizes three vendor-specific networks:

- TruHearing for routine hearing-related benefits and supplies
- EyeMed for routine vision services and supplies
- American Specialty Health® for chronic lower back pain acupuncture services

Our HMO plans may only cover hearing, vision and acupuncture services when supplied by providers that participate in the applicable network listed above.

Our PPO plans may only cover hearing, vision and acupuncture services at the in-network benefit and cost-sharing levels when supplied by providers that participate in the applicable network listed above. Providers are encouraged to call the customer service number on the member's ID card if they have any questions around services that may or may not be covered.

Please inform members if you participate in any of these vendor-specific networks before providing related services. To explore participating in these vendor-specific networks, visit the vendors' websites.

- TruHearing: [TruHearing.com](https://www.truhearing.com) > For Providers > Join us
- EyeMed: [EyeMed.com](https://www.eyemed.com) > Providers: Providers Home > [Get More Information](#)
- American Specialty Health: [ASHLink.com](https://www.ashlink.com) > Join Our Network: [Providers](#)

EVICORE BY EVERNORTH

HealthSpring works with EviCore, a specialty medical benefits management company, to manage prior authorization of the services listed below. Effective Jan. 1, 2026, HealthSpring will manage prior authorizations for post-acute care services, including skilled nursing facility, inpatient rehabilitation, long-term acute care and home health.

High-tech radiology and diagnostic cardiology

- Computed tomography and CT angiography
- Magnetic resonance imaging and magnetic resonance angiogram
- Positron emission tomography
- Nuclear cardiology imaging
- Diagnostic cardiology
- Stress echoes

Medical oncology (excludes Part D coverage) and radiation therapy

- Medical oncology medications
- Outpatient radiation therapy treatment plans for both cancerous and noncancerous diagnoses

Musculoskeletal procedures

- Hip, knee and shoulder surgery
- Pain management services: Epidural steroid injections, facet injections, epidural adhesiolysis, spinal cord stimulator, pain pumps and radio frequency ablation

Durable medical equipment

- Durable medical equipment

Effective March 1, 2026, HealthSpring will manage durable medical equipment prior authorization.

Note:

- It is the responsibility of the performing facility or provider to confirm prior authorization has been obtained and approved prior to services being performed.
- Clinical guidelines, CPT code lists and additional resources are available at [EviCore.com/Provider](https://www.evicore.com/Provider).
- Visit [HealthSpring.com/Providers](https://www.healthspring.com/Providers) for information on submitting prior authorization requests to EviCore.

CLIA CERTIFICATION REQUIREMENT FOR LABORATORY SERVICES

CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments. CLIA was established to help ensure the accuracy and reliability of member test results. CLIA applies to all laboratories – including laboratories operating within physician offices and provider facilities – that examine “materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.” CLIA regulatory requirements vary according to the kind of tests each laboratory conducts. All health care providers that meet the definition of a “laboratory” under the CLIA statutes and regulations must obtain an appropriate CLIA certificate prior to conducting member testing.

Laboratory service providers seeking reimbursement from HealthSpring must ensure that the appropriate CLIA information is submitted with their claims using the correct loops, segments, and associated line level qualifiers.

Please refer to the ANSI X12N 837 Professional Claim Guidelines and the Medicare Claims Processing Manual chapters 1, 16, 26 and 35 for more information.

HealthSpring reserves the right to deny any claim submitted by a provider that cannot demonstrate appropriate CLIA certification. HealthSpring also reserves the right to deny claims for covered laboratory services that do not contain appropriate CLIA information and to apply claim line edits if the laboratory certification level does not support the billed service code.

Additional information regarding CLIA may be found on [CMS.gov](https://www.cms.gov) > Medicare > Quality: [Clinical Laboratory Improvement Amendments \(CLIA\)](#).

HealthSpring contracts may contain references to an in-office lab procedure list in the HealthSpring Administrative Guidelines or the provider manual. HealthSpring no longer includes a specific list in the provider manual and any such restriction to a list of in-office lab procedures contained in the HealthSpring Administrative Guidelines or the provider manual is deemed to be no longer in effect.

Providers should only provide services for which they are properly CLIA certified or for lab tests that are considered to be CLIA-waived, as determined by the U.S. Food & Drug Administration. Additional information on CLIA-waived tests is on the [FDA website](https://www.fda.gov).

DME POS SUPPLIER ENROLLMENT REQUIREMENT

CMS requires durable medical equipment, prosthetics, orthotics and supplies Medicare suppliers to attain

accreditation to ensure industry standards are met and to maintain high levels of excellence in service and supplies. In order to obtain and retain Medicare DMEPOS billing privileges, suppliers must be in compliance with the current version of the supplier standards, listed in their entirety in 42 § C.F.R. 424.57[©]. Once a supplier has obtained accreditation, they may enroll in the Medicare program as a DMEPOS supplier and receive Medicare reimbursement.

HealthSpring reserves the right to deny any claim submitted by a provider that cannot demonstrate appropriate DMEPOS supplier enrollment in the Medicare program.

Home Infusion Therapy Enrollment Requirement

CMS requires home infusion therapy suppliers to be accredited by a Medicare-approved accreditation organization and to enroll in Medicare as a Part B HIT supplier.

Section 1861(iii)(3)(D)(i) of the Social Security Act defines a qualified HIT supplier as a pharmacy, physician or other provider of services or supplier licensed by the state in which the pharmacy, physician or provider of services or supplier furnishes items or services and that:

- Furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs
- Ensures the safe and effective provision and administration of home infusion therapy on a seven-day-a-week, 24-hour-a-day basis (MLN Matters SE19029 Related CR N/A page 2 of 8)
- Is accredited by an organization designated by the Secretary pursuant to section 1834(u)(5)
- Meets such other requirements as the Secretary determines appropriate

A qualified home infusion therapy supplier may subcontract with a pharmacy, physician, provider of services or supplier to meet the requirements listed above.

HealthSpring reserves the right to deny any claim submitted by a provider that cannot demonstrate appropriate HIT supplier enrollment in the Medicare program.

CLINICAL REVIEW SERVICES

Overview

The HealthSpring Clinical Review Services department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate and cost-effective manner for the member.

HealthSpring or a third party delegated by HealthSpring to administer utilization management (the “delegated utilization management agent”) will provide a full range of customary utilization review and care management services and, except in the case of an emergency medical condition, provide prior authorization for those services if required by the member’s benefit plan, including hospital inpatient stays or confinement. You are responsible to participate in and comply with the HealthSpring utilization management program requirements and, to the extent applicable, the delegated utilization management agent’s utilization management program, and provide medical records and other information, including access to electronic health records, as requested.

The HealthSpring Clinical Review Services staff base their utilization-related decisions on the clinical needs of members, the member’s benefit plan, well-established clinical decision-making support tools, the appropriateness of care, CMS guidelines, health care objectives and clinical criteria based on current evidence in widely used treatment guidelines or clinical literature in the context of provider- and/or member-supplied clinical information and other such relevant information.

HealthSpring in no way rewards or incentivizes, financially or otherwise, providers, utilization reviewers, clinical care managers, physician advisers or other individuals involved in conducting utilization review, issuing denials of coverage or service, or inappropriately restricting care. The goal of HealthSpring is to:

- Ensure that services are authorized at the appropriate level of care and covered under the member's health plan benefits
- Monitor utilization practice patterns of HealthSpring contracted physicians, hospitals, ancillary services and specialty providers
- Provide a system to identify high-risk members and ensure that appropriate care is accessed
- Provide utilization management data for use in the process of recredentialing providers
- Educate members, physicians, contracted hospitals, ancillary services and specialty providers about our goals for providing quality, value-enhanced managed health care
- Improve utilization of HealthSpring resources by identifying patterns of overutilization and underutilization that have opportunities for improvement

Utilization Management Requests

The Clinical Review Services department consists of nonclinical and clinical support staff trained to receive requests via portal, fax, telephone and mail. Pertinent information will be requested to efficiently and accurately process the medical necessity determination. Upon submission of the request, please be prepared with all necessary information that may include, but is not limited to:

- Member name and identification number
- Location of service (e.g., hospital or ambulatory care setting)
- PCP name and TIN or Provider Identification Number
- Requesting provider name, including NPI
- Servicing provider name, including NPI
- Date of service
- Accurate diagnosis
- Service, procedure or surgery description, along with CPT codes or HCPCS codes
- Clinical information supporting the need for the service to be rendered

As necessary, requests will be forwarded to clinically licensed staff to complete a review to ensure benefit coverage, medical necessity and appropriateness of provider and place of service. Requests that cannot be approved utilizing applicable Medicare statutes, regulations, NCDs or LCDs, or internal criteria based on current evidence in widely used treatment guidelines or clinical literature will be forwarded to a pharmacist or medical director for review.

Approval notification may be delivered electronically, orally or in writing.

Denials for medical necessity are issued only by appropriately licensed personnel, such as a medical director or pharmacist, depending on the type of service request.

The decision also may be based on administrative guidelines. The medical director or pharmacist, in making the decision, may discuss alternative covered services with the requesting provider. If the medical director makes a determination to deny or limit an admission, procedure, service or extension of stay, HealthSpring or the delegated utilization management agent notifies the facility or provider's office of the denial. Such notice is issued to the member and, when appropriate, to the provider, documenting the original denied request, the rationale for the decision, the approved service (if applicable) and the process for filing an appeal.

Denial rationale will include the specific clinical criteria or benefits provision used in the determination of the denial. Written notifications are sent in accordance with CMS and National Committee for Quality Assurance

requirements to the provider and/or member. HealthSpring medical policies are publicly accessible at [HealthSpring.com/Providers](https://www.healthspring.com/providers). Upon request, the provider or member may receive a copy of the clinical criteria used in the decision. To request clinical criteria, call **800-230-6138**, Monday through Friday, 8 a.m. to 5 p.m. CT.

HealthSpring gives providers the opportunity to discuss utilization management authorization determinations with a medical director. A one-time, pre-decision, peer to peer may be available for initial concurrent hospital admission authorization reviews before a determination is made. Please refer to the “Concurrent review” section of this manual for additional information.

After a decision is rendered, a peer-to-peer conversation may occur to allow the provider to understand the denial rationale and the utilization review criteria applied. Decisions cannot be altered with the peer-to-peer process. For reconsideration of an adverse determination, the provider must initiate an appeal. HealthSpring will inform the treating provider of the availability of this process when notifying them of the prior authorization denial.

HealthSpring does not, in any way, reward or incentivize – financially or otherwise – clinical practitioners, utilization review staff, clinical care managers, physician advisers or any individuals involved in conducting reviews for issuing denials of coverage or service or inappropriately restricting care.

Departmental functions:

- Prior authorization
- Concurrent review
- Retrospective review
- Discharge planning
- Population health operations program goals
- Continuity of care

Prior Authorization

HealthSpring requires prior authorization for certain services, medications, procedures and equipment before they are performed or provided. This process helps prevent unnecessary utilization while ensuring members have access to the most appropriate, medically necessary care. The prior authorization is typically requested by the ordering provider but may also be initiated by the rendering provider.

In-network providers are responsible for requesting prior authorization on behalf of the member when required, at least seven calendar days in advance of the admission, procedure or service when possible. Requests must include all pertinent clinical information to support the medical necessity of the services requested. The member may also request a determination prior to delivery of services. If this occurs, HealthSpring or the delegated utilization management agent will contact you for the clinical information needed to support the request.

If prior authorization cannot be obtained in a timely manner, HealthSpring or the delegated utilization management agent and the appropriate participating provider must be notified, as applicable, as soon as possible, but no later than 24 hours after providing or ordering the covered services, or on the next working day. Failure to comply with request and/or notification timelines could result in an adverse determination.

Access our interactive prior authorization requirements at [HealthSpring.com/Providers](https://www.healthspring.com/providers) > Coverage and Claims. To search our prior authorization guide for a code, enter Ctrl+F > the five-digit code. If you are uncertain about the prior authorization requirement for a specific procedure, you may also contact Provider Customer Service.

To access the prior authorization forms, go to [HealthSpring.com/Providers](https://www.healthspring.com/providers) > Working With Us > Forms. Please complete forms in their entirety and attach pertinent clinical information.

Prior authorization is a determination of medical necessity and is not a guarantee of claims payment. Claim

reimbursement may be impacted by various factors, including the member's eligibility, plan participation status, benefits at the time the service is rendered and adherence to request and/or notification timeline requirements.

The presence or absence of a service or procedure on the list does not determine coverage or benefits.

How to request prior authorization

HealthSpring offers multiple ways to request prior authorization:

- **Through our self-service portal:** Log in to [Availity Essentials](#) or call Provider Customer Service at 800-230-6138 to verify a member's benefits, coverage and eligibility. After confirming eligibility and benefits, access the prior authorization portal through the HealthSpring Medicare Advantage Payer Space and submit all supporting documentation.
- **By mail:**
HealthSpring Medicare Advantage
Attn: Prior Authorization
500 Great Circle Road
Nashville, TN 37228
- **Or call or fax for prior authorization**

Contact	Phone	Fax
Behavioral health (all markets)	866-780-8546	866-949-4846
Drugs/biologics Part B	888-454-0013	877-730-3858
CareAllies	844-359-7301	866-233-6235
Clinical operations	800-453-4464	866-287-5834

Phone lines are staffed Monday through Friday, 8 a.m. to 5 p.m. CT.

The Clinical Review Services department, under the direction of licensed nurses, clinical pharmacists and medical directors, documents and evaluates requests for prior authorization, including:

- Confirmation that the member is eligible for HealthSpring plan coverage at the start of care
- Verification that the requested service is a covered benefit under the member's benefit package
- Determination of the appropriateness of the services (medical necessity)
- Validation that the service is being provided by the appropriate provider and in the appropriate setting

The Clinical Review Services department documents and evaluates requests using CMS guidelines, nationally recognized criteria and publicly accessible internal medical policies to make a determination of coverage. The provider may be notified electronically, orally or in writing within the regulated CMS time frames.

It is essential to submit clinical information at the time of the request. HealthSpring may outreach to you for information needed to make a determination. Requests received without supporting documentation may experience delays in processing up to the regulatory time frames, as CMS rules require that appropriate information be requested before decisions are rendered. See the Prior authorization request time frames section for details regarding decision and notification time frames.

For members who go to an emergency department for treatment, an attempt should be made in advance to contact

the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a member appears at an emergency department for nonemergency care, the PCP should be contacted for direction. Members may utilize urgent care facilities to treat conditions that are nonemergencies but require immediate treatment. HealthSpring must be notified whenever any of its members visit an emergency department for observation or inpatient care. Please be prepared to discuss the member's condition and treatment plan with our nurse case manager.

Prior authorization forms

To access our prior authorization forms, go to [HealthSpring.com/Providers](https://www.healthspring.com/providers) > Working With Us > Forms. It is important to use the forms when faxing a prior authorization request (along with the supporting clinical information) to ensure we have all the information needed to make a determination.

We update prior authorization requirements on a quarterly basis to align with program or CPT and HCPCS code changes. For that reason, it is important to check the prior authorization requirements before delivering planned services.

Prior authorization request time frames

Emergency

An emergency medical condition is a medical condition, mental or physical, 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.

Prior authorization is not required for an emergency medical condition. Notification of admission to inpatient or observation is required within 24 hours of admission or the next business day.

Expedited

An expedited request can be made when a physician believes that waiting for a decision under the routine or standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy.

Expedited requests will be reviewed, and a determination made. Notification will be provided as expeditiously as the member's condition requires, but no later than 72 hours after receiving the request.

To help us effectively address our members' urgent care needs, HealthSpring recommends reserving expedited requests for services that meet the above criteria. Expedited requests should not be used as a matter of convenience for scheduled services.

Routine or standard

A routine or standard prior authorization request will be reviewed, and a determination will be made. Notification will be provided as expeditiously as the member's health condition requires, but no later than seven calendar days after receiving the request.

HealthSpring Medicare Advantage medical policy development and application

Medicare Advantage medical policies identify the clinical criteria for determining when medical services are considered “reasonable and necessary” (medically necessary). Medicare Advantage plans are required by CMS to provide coverage of all services to Medicare Advantage members that are available to traditional Medicare beneficiaries.

Medicare Advantage plans must comply with National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and general coverage and benefit conditions included in traditional Medicare laws. This includes criteria for determining whether an item or service is a benefit available under traditional Medicare. When criteria are not fully established in Medicare statute, regulation, NCD or local LCD, Medicare Advantage organizations may create publicly accessible internal criteria that are based on current evidence in widely used treatment guidelines or clinical literature.

If additional unspecified criteria are needed to interpret or supplement generalized provisions within a Medicare law or coverage policy, there is flexibility allowed in the NCD or LCD, or there is no applicable NCD or LCD available to determine medical necessity, then other evidence-based criteria may be applied.

(42 C.F.R. § 422.101(b)(6)(i)) outlines the circumstances under which Medicare Advantage organizations may rely on internally developed criteria:

- i. Coverage criteria not fully established. Coverage criteria are not fully established when:
 - A. Additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently. The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services;
 - B. NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD; or
 - C. There is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.

Rationale supporting the adoption and use of internally developed medical policies: When medical criteria are not fully established (as defined in 42 C.F.R. § 422.101(b)(6)(i)) in Medicare law, an NCD or an LCD, CMS allows a Medicare Advantage organization like HealthSpring to create and use internally developed medical criteria. HealthSpring will exhaust all traditional Medicare laws, NCDs and applicable LCDs prior to using internal criteria policies to supplement general provisions. An internally created medical policy is utilized for the member’s specific condition where a Medicare law, NCD or LCD is not fully established. This includes when specific clinical presentation of the enrollee for the request under review is not addressed in the Medicare medical policy or there are no specific coverage criteria included in a Medicare policy. Medicare policies may provide broad provisions, which may be instructive but are not detailed enough to be used to determine the medical necessity of the request. Additionally, internal medical policies may be used when a Medicare policy includes statements that allow for health benefits beyond what is written in the Medicare policy.

Under the framework outlined above, HealthSpring may apply internally developed medical policies to the request under review. Each HealthSpring medical policy is developed based on widely used treatment guidelines or clinical literature. Each medical policy developed and used identifies clinical benefits, weighs the clinical benefits with any harm and addresses access to services. Additionally, the unique clinical circumstances of each member are considered alongside current CMS guidelines and the applicable HealthSpring medical policy whenever possible.

The hierarchy of decision includes that the service must be:

- A covered benefit in the member's evidence of coverage,
- A benefit that is not otherwise excluded and
- Appropriate and medically necessary

Clinical guidelines that may be utilized during the clinical review process include:

- Administrative policies
 - Evidence of Coverage
 - Utilization management policies and procedures, such as network adequacy, continuity of care and transition of care
- Medicare Coverage Manuals or other CMS-based resource:
 - Medical Benefit Policy Manual
 - Medicare Program Integrity Manual
 - Medicare Managed Care Manual
- Medicare National Coverage Determinations (NCDs)
- Local Coverage Determinations and Articles (LCDs and LCAs)
 - LCDs are used per jurisdiction
 - Out of Jurisdiction LCDs: Rules are defined for using LCD outside of jurisdiction
- MCG
- ASAM (American Society of Addiction Medicine) Medical Necessity Guidelines
- HealthSpring internal medical policies (evidence-based)
- Evidence-based literature
- Step therapy

HealthSpring medical policies are available at [HealthSpring.com/Providers](https://www.healthspring.com/Providers), or call Customer Service at 800-230-6138.

Discharge Planning

Discharge planning is a critical component of the process that begins with an early assessment of the member's potential discharge care needs to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the member and their family for any discharge needs, along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. The HealthSpring Concurrent Review staff will coordinate with the facility's discharge planning team to assist in establishing a safe and effective discharge plan.

Notification of discharge from observation or inpatient admissions and a copy of the discharge summary must be

sent to the HealthSpring Clinical Review Services department within one business day of the discharge date.

Inpatient coordination of care and concurrent review

Concurrent review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of care during observation, inpatient (acute, long-term acute care, rehabilitation) and skilled nursing facility admissions to ensure:

- Covered services or supplies must be medically reasonable and necessary and provided at the appropriate level of care by a physician, hospital or other health care provider licensed by the appropriate state or federal agency, or as otherwise approved by HealthSpring.
- Services must align with the member's symptoms, diagnosis, condition, disease, ailment or injury, and must not be experimental or investigational.
- Services should not be primarily for the personal comfort or convenience of the member, their family or the physician, hospital or other health care provider.
- Services must represent the safest and most appropriate supply or level of services, adhering to the accepted standards of good medical practice.
- Services must be delivered in accordance with the terms of the facility's contract.

All requests for admission, including observation and inpatient level of care, are subject to a medical necessity review. The mere fact that a provider has prescribed, performed, ordered or coordinated a service or course of treatment does not automatically make it medically necessary. In making determinations as to whether a particular covered service is medically necessary, HealthSpring will consider the terms of the member's benefit plan, Medicare statutes and regulations, national and local coverage guidelines, widely used treatment guidelines or clinical literature and such complex medical factors as the member's history and comorbidities, the severity of signs and symptoms, current medical needs and the risk for an adverse event, as supported by the medical record. No service is a covered service unless it is medical necessary.

HealthSpring requires admission notification for the following:

- Elective observation and acute admissions
- Emergent/urgent observation and acute admissions
- Intent to transfer to acute rehabilitation, long-term acute care or a skilled nursing facility, as these admissions require prior authorization
- Observation and acute admissions following outpatient procedures

Emergency or urgent admission notification must be received via fax or phone within 24 hours of admission or the next business day, whichever is later, even when the admission was prescheduled. Failure to comply with notification timelines could result in an adverse determination.

If the member's condition is unstable and the facility is unable to determine coverage information, HealthSpring requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information to hospital professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

The HealthSpring preferred method for concurrent review is EHR access. We can also receive concurrent review documentation via fax. We encourage live dialogue between our Concurrent Review nursing staff and the facility's utilization management staff to assist with discharge planning and needs. We should receive admission notification and clinical information within 24 hours of admission or observation status. If we do not receive clinical information within 72 hours of admission or the last covered day, we will review the case for medical necessity with the information we have available.

Observation level of care is an alternative to an inpatient admission that is a well-defined set of specific, clinically appropriate services. This includes ongoing short-term treatment assessment and reassessment that are furnished while a decision is being made about whether the member will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital. Observation level of care is not expected to exceed 24 hours but may extend to 48 hours. Discharge or admission must occur less than 48 hours after the member is admitted to observation status. There will be no reimbursement for observation services in excess of 48 hours unless otherwise specifically stated in your provider services agreement. Observation services in excess of 48 hours are subject to administrative denial.

Facilities may submit the member's clinical information within 24 hours of notification using the appropriate contact information below.

Area	Website	Phone	Fax
Inpatient/observation admissions	N/A	888-454-0013	866-234-7230
Texas CareAllies inpatient/observation admissions	N/A	844-359-7301	888-205-9577

Following an initial determination, the concurrent review nurse will request additional updates from the facility on a case-by-case basis. The criteria used for the determination is available to the provider or facility upon request. HealthSpring will render a determination within three calendar days after receipt of complete clinical information. The HealthSpring nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a determination. Clinical update information should be received 24 hours prior to the next review date.

A medical director reviews all acute confinements that do not meet medical necessity criteria and issues a determination. If the medical director deems that the inpatient confinement does not meet medical necessity criteria, the medical director will issue an adverse determination (a denial). The Concurrent Review Nurse or designee will notify the provider(s) (e.g., facility, attending or ordering provider) of the adverse determination via a notice of denial.

Under the guidelines established by CMS for the Acute Hospital Care at Home program, participation by Medicare Advantage plans is not mandatory. HealthSpring has chosen not to participate in the hospital at home program and, therefore, Revenue Code 0161: Hospital at Home, will not be reimbursed.

The HealthSpring Clinical Review Services department complies with individual facility contract requirements for concurrent review decisions and time frames. HealthSpring nurses, utilizing CMS guidelines and nationally accepted, evidence-based review criteria, will conduct the medical necessity review.

HealthSpring is responsible for final prior authorization.

Adverse determinations – concurrent review

Rendering of adverse determinations (denials)

The HealthSpring Clinical Operations staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits or eligibility.

Every effort is made to obtain all necessary information, including pertinent clinical information and original

documentation from the treating provider to allow the medical director to make appropriate determinations.

Only the medical director may render an adverse determination (denial) based on medical necessity. The medical director, in making the initial decision, may discuss an alternative covered service to the requesting provider. If the medical director makes a determination to limit an admission or deny an extension of stay, HealthSpring notifies the requesting provider of partial approval of service, documenting the original request that was denied and, if applicable, the alternative approved service, along with the process for provider payment reconsideration. If the medical director makes a determination to deny an admission, HealthSpring notifies the requesting provider of the denial of service, documenting the denial rationale and the process for appeal.

HealthSpring gives providers the opportunity to discuss utilization management authorization determinations with a plan medical director.

A one time, pre-decision opportunity to discuss (peer to peer) may be eligible to be performed during the initial concurrent review process for hospital admission authorizations, prior to the UM determination being made. Please relay any intent for a pre-decision peer to peer discussion and physician, NP/PA contact information within the initial concurrent UM review and as soon as possible.

Following an adverse determination, a change in decision cannot be made outside of the appeals process. Peer-to-peer requests in the absence of an appeal will be informational only and cannot change a UM decision.

New or additional information, including but not limited to: a change in status, new event or decompensation in clinical status for reconsideration of a denial may only be submitted via appeal.

Appeals instructions are included on the utilization management denial notice transmitted to the hospital and member and under the Appeals section on page 23 of this manual.

Provider appeals submitted on behalf of the member must:

- Ensure the member is aware of the appeal on their behalf
- Include a signed, valid CMS Appointment of Representative (AOR) form (CMS 1696)

A copy of the form is accessible via [CMS.gov](https://www.cms.gov) > CMS Forms

Providers are eligible to appeal coverage decisions if they are submitted by the ordering or treating physician, or by a representative acting on behalf of the ordering or treating physician. Ensure the ordering/treating physician information is available upon submission of an appeal.

Payment decisions and claims denials must be pursued via the Contracted provider post-service dispute process. You can access appeals and dispute forms at Healthspring.com/Providers > Forms.

Notification of adverse determinations (denials)

The reason for each denial – including the specific utilization review criteria with the pertinent subset/information or benefits provision used in the determination of the denial – is included in the written notification and sent to the provider and member, as applicable. Written notifications are sent in accordance with CMS and NCQA requirements to the provider and/or member as follows:

- For urgent concurrent decisions: Within 72 hours of the request
- For postservice decisions: Within 30 calendar days of the request

Retrospective review

Retrospective review is the process of determining coverage for clinical services by applying guidelines and criteria to support the claim adjudication process after the prior authorization or concurrent review time frame has passed. Listed below are the only scenarios in which retrospective requests can be accepted:

- Prior authorizations for claims billed to an incorrect payer.
- If you have not submitted the claim to HealthSpring yet and received a denial from an incorrect payer, you can request a retrospective prior authorization from Clinical Review Services within two business days of receiving the remittance advice from the incorrect payer.
- If you have already submitted the claim to HealthSpring and received a denial, you cannot request a retrospective prior authorization; however, you can request an appeal (you must follow the guidelines for submitting an appeal).
- HealthSpring will retrospectively review any medically necessary services provided to HealthSpring members after hours, holidays or weekends. The retrospective prior authorization request and applicable clinical information must be submitted to the Clinical Review Services department within one business day of the start of care.

In accordance with HealthSpring policy, retrospective requests for prior authorizations not meeting the scenarios listed above will not be accepted and claims may be denied for payment.

Readmission quality program

The HealthSpring Readmission Quality program applies to readmissions that occur as an acute inpatient admission for a same or similar diagnosis at a facility under the same TIN or contract.

Patient engagement and follow-up during the 31-day period following discharge can help reduce readmissions, which is a national goal that CMS supports to improve the quality of care of Medicare beneficiaries. In accordance with your contract, you may not bill the member for covered services denied by HealthSpring.

HealthSpring will reimburse for readmissions for the same or similar diagnosis at a facility or a facility operating under the same TIN as follows:

- Readmissions within 48 hours from the date of discharge from the original acute inpatient admission (referred to as the index admission):
 - The facility will *not* be reimbursed for the readmission regardless of the readmission length of stay. CMS generally considers a short-term readmission for the same or similar diagnosis to be the result of a process failure in discharge planning or the patient not being clinically stable at the time of the original discharge.
 - HealthSpring medical directors will not conduct medical necessity reviews of admissions within 48 hours from the date of discharge from the original acute inpatient admission; they will review the readmission to determine if a same or similar diagnosis is present.
- Readmissions within three to 31 days from the date of discharge from the original acute inpatient admission (referred to as the index admission):
 - The higher weighted diagnosis-related group between the index admission and the readmission will be paid at the normal contracted rates.
 - The days, diagnoses and procedures from the lower weighted DRG admission will be included in the paying DRG calculation.
 - A second and any additional readmissions that occur within the original 31-day window from the index

admission discharge will bundle into the initial admission if the above parameters are met. A new index admission is set once a full 31 days has elapsed.

- HealthSpring medical directors will conduct medical necessity reviews of admissions within three to 31 days from the date of discharge and evaluate whether a same or similar diagnosis is present, as well as a modifiable cause.

For per diem: 100 percent per day of first admission; 85 percent per day of the readmission. Program exclusions include:

- Observation admissions; these are reimbursed according to the facility agreement
- Readmissions for patients undergoing active chemotherapy treatment or who are in the immediate post-transplant period (31 days)
- Planned and approved elective admissions that occur within 31 days of acute inpatient discharge; these are reimbursed according to the facility agreement
- Transfers from out-of-network facilities to in-network facilities
- Transfers of patients to receive care not available at the first facility
- Admissions with a discharge status of "left against medical advice"
- Behavioral health, long-term acute care and inpatient rehabilitation admissions

All acute admissions are subject to this program unless your contract specifically dictates otherwise.

Skilled nursing facility care and levels

Unless otherwise specifically stated in your provider services agreement, patient level classification varies based upon the presenting condition of the member in conjunction with prior authorized services or medical necessity.

Services and supplies that are specifically excluded from skilled nursing facility consolidated billing are excluded from the level classifications below and should be billed in accordance with CMS billing guidelines.

The following standard services are included in all levels of care:

- Semiprivate room
- Meals
- Provisions of enteral and parenteral nutrition
- 24-hour nursing care and rehabilitation nursing services
- Pharmacy
- Routine medication
- Supplies
- Pharmacy consultation
- Standard durable medical equipment.
- Routine oxygen
- Routine medical and surgical supplies
- Routine laboratory services (e.g., PT, PTT, CDC, UA, C&S, SMA-7 and blood glucose)
- Chest X-rays, up to one per week
- Routine doppler studies
- Discharge planning
- Teaching, training or observation by skilled nursing or rehabilitation staff
- Case management
- Recreational therapy
- Social services

Note:

- Reimbursement will revert to Level I on days in which therapy is not provided. Therapy logs are to be submitted to the Post-Acute Concurrent team on a weekly basis. Dates of service for which therapy logs have not been submitted to Clinical Operations, HealthSpring or the delegated utilization management agent within seven days of discharge will be reimbursed at Level I rates.
- Post-acute care facilities are required to submit concurrent review requests two days prior to the current authorization end date.

Service	Definition
SNF Level I RevCode 191	<p>Includes the standard services listed above and all of the following services:</p> <ul style="list-style-type: none"> • Minimum three hours per day direct skilled nursing intervention • No active treatment of comorbidities or stable comorbidities • Assessment of vitals and body systems (required one to two times per day) <p>Must also include one or more of the following services</p> <ul style="list-style-type: none"> • IV infusion – Pump and supplies, fluids for hydration • Pain management administered intramuscular or subcutaneous • Feeding tube post placement

SNF Level II RevCode 192	<p>Includes the standard services listed above, Level I services and all of the following services:</p> <ul style="list-style-type: none"> • Three to six hours per day direct skilled nursing intervention • Active treatment of comorbidities (required) • Assessment of vitals and body systems (required two to three times per day) <p>Must also include one or more of the following services:</p> <ul style="list-style-type: none"> • Wound care for the following treatments: <ul style="list-style-type: none"> – Surgical and amputation sites (requires two treatments per day) – Decubitus Stage 2 or greater with necrotic tissue (one or more treatments per day) – Venous stasis ulcer Stage 2 or greater with necrotic tissue (one or more treatments per day) – Cellulitis (requires two treatments per day) – Burns with grafting (requires mechanical debridement or two treatments per day) • Acute colostomy, ileostomy, super-pubic catheter care, or peritoneal dialysis, including training and supplies • Tracheostomy – stable • IV infusion for pain management • Therapy (e.g., physical, speech, occupational)
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<p>SNF Level III Rev Code 193</p>	<p>Includes the standard services listed above, Level I and II services, and all of the following services:</p> <ul style="list-style-type: none"> • Three to six hours per day direct skilled nursing intervention • Active medical care and treatment of comorbidities (required), with the potential for the comorbidities to affect the treatment plan • Assessment of vitals and body systems is required three to four times per day. <p>Must also include one or more of the following services:</p> <ul style="list-style-type: none"> • IV infusion via subclavian line, central line, peripherally inserted central catheter, including pump, maintenance and supplies • IV medication with an average wholesale price less than \$100 per day all doses combined • Total parenteral nutrition administration • Wound care for the following treatments: <ul style="list-style-type: none"> – Decubitus – multiple Stage II sites (one or more treatments per day) – Decubitus – Stage III or greater (one or more treatments per day) – Mechanical or sharp debridement of necrotic tissue, excludes autolytic and/or enzymatic debridement, sterile packing and/or compression bandaging drainage tubes – Pulsed lavage daily treatments (excludes whirlpool) • Tracheostomy with suctioning up to three times per day • Oxygen, high concentration, nebulizer, mist • Isolation for infection control (does not include contact isolation) • Therapy (physical, speech, occupational): <ul style="list-style-type: none"> – Therapy evaluations (physical, occupational, speech), as indicated – Therapy treatments greater than two hours per day
<p>SNF Level IV Rev Code 194</p>	<p>Includes the standard services listed above, Level I, II, and III services, and all of the following services:</p> <ul style="list-style-type: none"> • Intensive care – six to eight hours per day skilled nursing and technical intervention • Active medical care and treatment of comorbidities (required) • No active treatment of comorbidities or stable comorbidities • Assessment of vitals and body systems (required four to six times per day) <p>Must also include one or more of the following services:</p> <ul style="list-style-type: none"> • Chronic vent care, including supplies, blood gases, pulse oximetry, pulmonary testing and pulmonary rehabilitation) • Tracheostomy care with frequent suctioning/coughing, greater than three times per shift • Administration of chemotherapy or IV medication with an Average Wholesale Price greater than \$100 per day, all doses combined • Complex wound care and skin disorders: <ul style="list-style-type: none"> – Stage IV decubitus (two or more treatments per day) – Multiple wound sites requiring debridement, packing or sterile technique
<p>SNF Level V Rev Code 199</p>	<p>Includes the standard services listed above, Level I, II, III, and IV services, and all of the following services:</p> <ul style="list-style-type: none"> • Intensive care of six to eight hours per day skilled nursing and technical intervention • Active medical care and treatment of comorbidities (required) • No active treatment of comorbidities or stable comorbidities • Assessment of vitals and body systems (required four to six times per day vent care • Vent care for weaning; chronic vent care, including supplies, blood gases, pulse oximetry, pulmonary testing, pulmonary rehabilitation and documented weaning trials

Notice of Medicare Non-Coverage

A HealthSpring or delegated utilization management agent reviews all ongoing skilled nursing services that do not meet medical necessity criteria and issues a determination. If the HealthSpring medical director deems that a continued stay is not medically necessary, the medical director will issue an adverse determination (a denial).

HealthSpring or the delegated utilization management agent will issue a Notice of Medicare Non-Coverage to the skilled nursing facility with adverse organization determinations or denials when it is determined that services will end, and discharge is anticipated in accordance with CMS guidelines. The skilled nursing provider is responsible for delivering the notice to the member or their authorized representative or power of attorney at least two calendar days prior to the end date of the currently approved authorization.

An NOMNC must be delivered even if the member agrees with the termination of services. The provider is responsible for ensuring that the member, authorized representative or power of attorney signs the notice within the specified time frame. The NOMNC includes information on a member's rights to file a fast-track appeal.

REFERRAL GUIDELINES

HMO Plans

The PCP is often the member's primary point of entry into the health care delivery system for all outpatient specialist care. For select HMO plans, the PCP may be required to obtain a referral for most outpatient specialist visits for HealthSpring members. The member's ID card will indicate if a referral is required, except for Arizona.

- PCPs should make referrals to HealthSpring Medicare Advantage in-network specialists.
- Out-of-network specialist visits require prior authorization.
- Referrals must be obtained prior to specialist services being rendered.
- PCPs should not issue retroactive referrals.
- Most referrals are valid for 120 days starting from the issue date.
- All requests for referrals must include the following information:
 - Member name
 - Member date of birth
 - Member ID
 - PCP name
 - Specialist name
 - Date of referral
- Number of visits requested
- Diagnosis

If a member is in an active course of treatment with an out-of-network specialist at the time of enrollment into a HealthSpring Medicare Advantage plan, a PCP referral is not required. However, prior authorization must be obtained from the Clinical Operations department. For further details, refer to the Continuity of Care section.

If a member needs care from a specialist, it is preferred they obtain the referral from their PCP.

PPO Plans

Referrals are not required for PPO plans. However, before receiving services from providers that do not participate in the network, the member may want to ask for a previsit coverage determination.

Plans That Require Referrals by State

In the table below, checkmarks indicate the types of Medicare Advantage plans that are available in each market listed. Diamonds indicate plans that require a referral to see an in-network specialist, with the exception of behavioral health (outpatient mental health) specialists for an HMO plan.

Market	HMO	HMO POS	PPO
Alabama			
Arizona			
Arkansas			
Colorado			
Connecticut (New England)			
Delaware			
Central Florida	✓ ♦	✓	✓
North Florida	✓	✓	✓
South Florida	✓ ♦		✓
Georgia	✓		✓
Illinois	✓	✓	✓
Kansas City	✓		
Maryland	✓		
Mississippi (Southern)	✓		
Nevada	✓ ♦		
New Jersey	✓		✓
New Mexico			
North Carolina			
Ohio			
Oklahoma	✓ ♦	✓	✓
Oregon (Portland)	✓	✓	✓
Pennsylvania	✓	✓	✓
South Carolina	✓	✓	✓
St. Louis/Southern Illinois	✓	✓	✓
Tennessee	✓	✓	✓
Texas	✓ ♦	✓	✓
Utah			
Virginia			

Washington	✓		✓
Washington, D.C.			

How to Obtain a Referral

There are four ways a PCP can obtain a referral to a specialist:

- **Provider self-service portal [Availity Essentials](#)** (preferred method): Our provider portal is available 24 hours a day, 365 days a year. You can submit and follow the request online, which will help ensure accurate and timely processing of referrals. Log in to [Availity.com](#) and access the referral portal through the HealthSpring Medicare Advantage Payer Space.
- **Fax:** Complete the referral form on the Forms page at [HealthSpring.com/Providers](#) and fax it to our Referral department at the number indicated on the form.
- **Mail.** Complete the referral form and mail it to HealthSpring Medicare Advantage, Attn: Precertification Department, 500 Great Circle Road, Nashville, TN 37228
- **Phone.** If the referral is for an emergency, you may obtain a referral by phone by calling the appropriate phone number below for your state.

Market	Contact				
Alabama	800-962-3016				
Arizona	Arizona plans do not require referrals.				
Colorado, Utah, New Mexico, Nevada Oregon and Washington	800-230-6138				
Florida	800-962-3016				
Southern Mississippi	866-949-7103				
Georgia (all counties except Catoosa, Dade and Walker)	866-949-7103; fax 855-420-4717				
North Carolina	866-949-7099				
South Carolina	866-949-7101				
Kansas City	888-454-0013				
Tennessee, Northern Georgia, and Arkansas.	800-453-4464				
Illinois, Ohio and Indiana	800-230-7298				
Oklahoma City, Texas and Southern Arkansas	<table border="1"> <tr> <td>HealthSpring prior authorization</td> <td>Durable medical equipment</td> </tr> <tr> <td> <ul style="list-style-type: none"> • Phone: 800-511-6932 or 832-553-3456 (local) • Fax: 888-856-3969 or 832-553-3426 (local) </td> <td> <ul style="list-style-type: none"> • Phone: 800-511-6932 or 832-553-3313 (local) • Fax: 888-205-8658 </td> </tr> </table>	HealthSpring prior authorization	Durable medical equipment	<ul style="list-style-type: none"> • Phone: 800-511-6932 or 832-553-3456 (local) • Fax: 888-856-3969 or 832-553-3426 (local) 	<ul style="list-style-type: none"> • Phone: 800-511-6932 or 832-553-3313 (local) • Fax: 888-205-8658
HealthSpring prior authorization	Durable medical equipment				
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Delaware, Maryland, New Jersey, Pennsylvania and Washington D.C.	888-454-0013; Fax 866-464-0707				

PCP Referral Responsibilities

A PCP is responsible for ensuring a member has a referral prior to the appointment with the specialist.

Specialist Physician's Referral Responsibilities

In some areas, specialists must have a referral from a PCP prior to seeing a member. Claims may be denied if a specialist sees a member without a referral when one is required one; we are unable to make exceptions to this requirement. To verify that a referral has been made, the specialist may log in to the [Availity Essentials](#) self-service portal, contact the member's PCP or call HealthSpring to verify.

Referrals to Out-of-network Providers

HealthSpring strives to ensure the quality of care delivered by in-network providers. Referrals to out-of-network providers are not recommended as the quality of care cannot be effectively monitored for our members. Additionally, use of an out-of-network provider may be excluded by the member's benefit plan or negatively impact the member's applicable cost-share. HealthSpring will consider a referral to an out-of-network provider only if there is a continuity-of-care issue, a network gap has been identified or a medically necessary circumstance in which the member's need cannot be met in network (e.g., a service or procedure is not provided in alignment with access and availability standards).

Prior authorization is required for referrals to out-of-network providers. Requests will be reviewed for the criteria above as described in the Prior Authorization section of this manual. While it is recommended that a PCP initiate requests for prior authorizations to providers, members or their authorized representatives may request prior authorizations on their own behalf. For PPO plans, prior authorization is only required for in-network and out-of-network services listed at [HealthSpring.com/Providers](https://www.healthspring.com/Providers) > Coverage and Claims. This allows us to confirm that these services are covered and medically necessary for:

- Inpatient hospital and skilled nursing admissions
- Outpatient procedures, services, and supplies

POPULATION HEALTH MANAGEMENT

HealthSpring has published and actively maintains a detailed set of program objectives (available upon request) in our care management program description. These objectives are clearly stated and measurable and have associated internal and external benchmarks against which progress is assessed and evaluated throughout the year. Plan demographic, epidemiologic and survey data are used to select program objectives, activities and evaluations.

Population Health Management Approach

Our population health management program is part of the broader population health management strategy. It is a comprehensive multidisciplinary approach to the management of members across the spectrum of care with chronic, complex and disease-specific care needs.

Key components of the population health management program are to provide early identification and intervention for members with medical, pharmaceutical or behavioral health needs who would benefit from:

- Improved self-management skills
- Referrals to adjunct programs
- Complex care management
- Assistance with coordinating plan benefits and/or community resources

- Reduction in the frequency and/or intensity of a chronic illness exacerbation
- Closure of gaps in preventive care measures

Members are stratified and identified for specific programs that meet their needs through a variety of mechanisms including referrals, data analysis for health resource patterns and predictive modeling. Prevalence rates and comorbidities in each individual market's population of members are evaluated for needed services.

Members may be referred for evaluation based on their health risk assessment results or by their PCP, specialist, inpatient review nurse or other ancillary services provider. Claim or encounter data, pharmacy data, laboratory results, data from the care management and utilization management process or care management (SNP) process, information from EHRs and member self-referral may also be used to identify members for disease-specific programs. The care management program content includes all information and interventions that the organization directs at members or providers to improve management of a condition or health maintenance (e.g., materials, member reminders, scripts for phone calls).

How to Use Services

Members who may benefit from care management are identified in multiple ways including, but not limited to, utilization management activities, predictive modeling and direct referrals from a provider.

Provider contact information

To refer a HealthSpring member for care management or care coordinator services, contact us:

- By phone: 866-382-0518, Option 2, Monday – Friday, 8 a.m. – 5 p.m. CT
- Or email: CareManagementSupport@HealthSpring.com

Member information

Our members have access to information regarding the program via a brochure and website and may self-refer. Our Population Health Operations staff contacts members by telephone. The member has the right to opt out of the program. Once enrolled, an assessment is completed with the member and a plan of care with goals, interventions and needs is established.

Coordination with network providers

HealthSpring offers members access to in-network facilities, PCPs and specialty care physicians, as well as behavioral health and alcohol and substance use disorder specialists, and an ancillary care network of providers. Each member receives a provider directory annually giving in-depth information about how to find participating providers in their area (by ZIP code and specialty), how to select a PCP (if required), conditions under which out-of-area and out-of-network providers may be seen and procedures for when the member's provider leaves the network. A toll-free Member Service phone number is provided that members can call if they have any questions. Members also have access to a series of web-based provider materials.

Our website allows members to search the [provider directory](#) for doctors, facilities and pharmacies.

Our Population Health Operations staff will work with you and your staff to meet the unique needs of each member. Care managers work with members and providers to schedule and prepare for member visits to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any nonclinical barriers to care. In cases where provider referrals are necessary, care managers work closely with members to identify appropriate providers, schedule visits and secure transportation.

Continuity of care

When a provider leaves the HealthSpring network and a member is in an active course of treatment, our Health Services staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. Members in their second or third trimester of pregnancy have access to the exiting provider through the postpartum period.

An active course of treatment is when a member has regular visits with the provider to monitor the status of an illness or a disorder, render direct treatment, prescribe medication or other treatment, or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition). The postpartum period begins immediately after childbirth and extends for approximately six weeks.

Continuity and coordination of care

The HealthSpring policy is to provide for continuity and coordination of care with medical and behavioral health providers treating the same member, and coordination between medical and behavioral health services.

HealthSpring monitors the continuity and coordination of care for health members annually by:

- Monitoring the use of high-risk medications in older adults
- Tracking potentially harmful drug disease interactions in older adults
- Eye exams for members with diabetes
- Following up after an emergency department visit by members with multiple high-risk chronic conditions
- Monitoring fall risk management
- Transition of care
- Planning all-cause readmissions
- Monitoring hospitalizations following discharge from a skilled nursing facility

Providers must agree to:

- Continue treatment for an appropriate period of time based on transition plan goals
- Share information about the treatment plan with the organization
- Continue to follow HealthSpring utilization management policies and procedures
- Charge only the required copayment

HealthSpring will work to transition a member into care with an in-network physician or other provider within the HealthSpring network, but is not required to provide continued access in the following circumstances:

- If the provider is unwilling to continue to treat the member or accept the organization's payment or other terms
- If the member is assigned to a provider group, rather than to an individual provider, and has

- continued access to providers in the contracted group
- If the contract is terminated based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.)

HealthSpring also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in the HealthSpring network. Under these circumstances, HealthSpring will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

HealthSpring will honor plans of care (including prescriptions, durable medical equipment, medical supplies, prosthetic and orthotic appliances, specialist referrals and any other ongoing services) initiated prior to a new member's enrollment for a period of at least 90 calendar days or until the PCP evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request prior authorization for such services, please review the following home health services section for contact information for care management services.

Home health services

HealthSpring requires prior authorization of home health services and utilizes CMS guidelines and review criteria based on widely used treatment guidelines or clinical literature to conduct medical necessity review of services.

Following the completion of the initial assessment by the home health agency, the home health agency has seven calendar days from the initial visit to establish the care plan and must include all visits needed to establish the plan of care specific to the member's needs when requesting prior authorization. Timely receipt of clinical documentation supports the clinical review process.

Failure to comply with notification timelines or failure to provide timely clinical documentation to support the need for home health services or continuation of home health services could result in an adverse determination.

A medical director reviews all home health services that do not meet medical necessity criteria and issues a determination. If the medical director deems that the services are not medically necessary, they will issue an adverse determination (a denial). HealthSpring, the delegated utilization management agent or designee will notify the provider and member verbally and in writing of the adverse determination via notice of denial.

HealthSpring or the delegated utilization management agent will issue a Notice of Medicare Non-Coverage to the home health provider when an adverse determination is rendered resulting in an end to all skilled nursing disciplines in the home.

It is the home health provider's responsibility to deliver the written NOMNC provided by HealthSpring in accordance with CMS guidelines. The home health provider is responsible for delivering the notice to the member or their authorized representative or power of attorney at least two calendar days prior to the end date of the currently approved authorization, or the second to last day of service if care is not being provided daily. For services less than two calendar days in duration, the provider is responsible to issue the NOMNC on the initial visit. An NOMNC must be delivered even if the member agrees with the termination of services. The provider is responsible for ensuring the member, authorized representative or power of attorney signs the notice within the specified time frame. The NOMNC includes information on the member's rights to file a fast-track appeal.

The home health provider is required to send a copy of the signed NOMNC back to HealthSpring or the delegated utilization management agent promptly to ensure the member's rights to file a fast-track appeal are preserved. Receipt of the NOMNC will be monitored. HealthSpring validates the appropriate receipt of the NOMNC back from home health providers in accordance with CMS guidelines.

POPULATION HEALTH MANAGEMENT CLINICAL PROGRAMS

HealthSpring telephonic patient support programs can serve as a customizable adjunct to your treatment plans and enable early intervention for your patients with medical, pharmaceutical, or behavioral health needs. The programs are supported by a multidisciplinary team of professionals and offered at no additional cost. Program eligibility will vary depending on the program and the member's benefit plan. For a full list of programs, refer to [HealthSpring.com/Providers](https://www.healthspring.com/providers) > Caring for Patients.

Benefits for you and your team

- Short-term and complex care management
- Assistance coordinating services and community resources
- Targeted efforts to prevent or manage complications

Benefits for your patients

- Improved self-management skills
- Better medication adherence
- Closed gaps in preventive care measures

To learn more, request an eligibility review for your patient, or refer a patient to Care Management, email CareManagementSupport@HealthSpring.com and include:

- Provider name and phone number.
- Patient name.
- Patient health ID number.

To obtain support with vendor programs:

Email VendorSupport@Healthspring.com and include the same information listed above.

Be sure to **use secure email** when sending diagnostic data and other patient personal or protected health information.

DRUGS/BIOLOGICS PART B (MEDICAL BENEFIT)

Drugs/biologics Part B are covered under the medical benefit in accordance with the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Managed Care Manual, Chapter 4. Requests for Drugs/Biologics Part B prior authorization are processed in accordance with Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Prior authorization requirements for Drugs/Biologics Part B are available on [HealthSpring.com/Providers](https://www.healthspring.com/providers) > Coverage and Claims.

Prior authorization requirements ensure appropriate drug utilization by following CMS guidelines according to national coverage determinations, local coverage determinations, Medicare Benefit Policy Manual and Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance.

HealthSpring Medicare Advantage medical policy development and application

Medicare Advantage medical policies identify the clinical criteria for determining when medical services are considered "reasonable and necessary" (medically necessary). Medicare Advantage plans are required by CMS to provide coverage of all services to Medicare Advantage members that are available to traditional Medicare

beneficiaries.

Medicare Advantage plans must comply with National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and general coverage and benefit conditions included in traditional Medicare laws. This includes criteria for determining whether an item or service is a benefit available under traditional Medicare. When criteria are not fully established in Medicare statute, regulation, NCD or local LCD, Medicare Advantage organizations may create publicly accessible internal criteria that are based on current evidence in widely used treatment guidelines or clinical literature.

If additional unspecified criteria are needed to interpret or supplement generalized provisions within a Medicare law or coverage policy, there is flexibility allowed in the NCD or LCD, or there is no applicable NCD or LCD available to determine medical necessity, then other evidence-based criteria may be applied.

(42 C.F.R. § 422.101(b)(6)(i)) outlines the circumstances under which Medicare Advantage organizations may rely on internally developed criteria:

- ii. Coverage criteria not fully established. Coverage criteria are not fully established when:
 - D. Additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently. The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services;
 - E. NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD; or
 - F. There is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.

Rationale supporting the adoption and use of internally developed medical policies: When medical criteria are not fully established (as defined in 42 C.F.R. § 422.101(b)(6)(i)) in Medicare law, an NCD or an LCD, CMS allows a Medicare Advantage organization like HealthSpring to create and use internally developed medical criteria. HealthSpring will exhaust all traditional Medicare laws, NCDs and applicable LCDs prior to using internal criteria policies to supplement general provisions. An internally created medical policy is utilized for the member's specific condition where a Medicare law, NCD or LCD is not fully established. This includes when specific clinical presentation of the enrollee for the request under review is not addressed in the Medicare medical policy or there are no specific coverage criteria included in a Medicare policy. Medicare policies may provide broad provisions, which may be instructive but are not detailed enough to be used to determine the medical necessity of the request. Additionally, internal medical policies may be used when a Medicare policy includes statements that allow for health benefits beyond what is written in the Medicare policy.

Under the framework outlined above, HealthSpring may apply internally developed medical policies to the request under review. Each HealthSpring medical policy is developed based on widely used treatment guidelines or clinical literature. Each medical policy developed and used identifies clinical benefits, weighs the clinical benefits with any harm and addresses access to services. Additionally, the unique clinical circumstances of each member are considered alongside current CMS guidelines and the applicable HealthSpring medical policy whenever possible.

The hierarchy of decision includes that the service must be:

- A covered benefit in the member's evidence of coverage,
- A benefit that is not otherwise excluded and
- Appropriate and medically necessary

Clinical guidelines that may be utilized during the clinical review process include:

- Administrative policies
 - Evidence of Coverage
 - Utilization management policies and procedures, such as network adequacy, continuity of care and transition of care
- Medicare Coverage Manuals or other CMS-based resource:
 - Medical Benefit Policy Manual
 - Medicare Program Integrity Manual
 - Medicare Managed Care Manual
- Medicare National Coverage Determinations (NCDs)
- Local Coverage Determinations and Articles (LCDs and LCAs)
 - LCDs are used per jurisdiction
 - Out of Jurisdiction LCDs: Rules are defined for using LCD outside of jurisdiction
- MCG
- ASAM (American Society of Addiction Medicine) Medical Necessity Guidelines
- HealthSpring internal medical policies (evidence-based)
- Evidence-based literature
- Step therapy

HealthSpring medical policies are available at [HealthSpring.com/Providers](https://www.healthspring.com/providers) > Coverage and Claims, or call Customer Service at 800-230-6138.

Prior Authorization

Obtain prior authorization for Drugs/Biologics Part B using one of the following methods:

- **Self-service portal Availity Essentials:** Log in to [Availity Essentials](#) and access the prior authorization portal through the HealthSpring Medicare Advantage Payer Space
- **Phone:** 888-454-0013 (Drugs/Biologics Part B Prior Authorization department)
- **Fax:** 877-730-3858 (Drugs/Biologics Part B Prior Authorization department)

Drugs/biologics Part B administered “incident” to a provider service must be billed by the provider or facility. Pharmacies may not bill Medicare Part B for drugs furnished to a provider for administration to a Medicare member. Drugs/biologics Part B may be administered, and a backdated authorization obtained, in cases of emergency.

See Prior authorization request time frames: For Part B drug requests, this time frame is no longer than 72 hours after receiving the request. See the Emergency section for the definition of emergency services and to review retroactive prior authorization request timelines.

Step Therapy

As part of the American Patients First Blueprint, Medicare Advantage plans have the option to apply step therapy for physician-administered and other Part B drugs in a way that lowers costs and improves the quality of care for Medicare members. Step therapy is a program that requires patients to try lower-cost options before “stepping up” to higher-cost. The allowance of step therapy practices for Part B drugs will help achieve the goal of lowering drug prices while maintaining access to covered services and drugs for members.

Step therapy prior authorization requirements for Part B drugs will apply to “new starts” only, and not to members who are currently and actively receiving medications (members with a paid claim within the past 365 days).

Prior authorization requirements, a step therapy quick reference guide and forms are available at [HealthSpring.com/Providers](https://www.healthspring.com/providers).

OUTPATIENT OBSERVATION NOTICE

Contracted Medicare hospitals and Critical Access Hospitals must implement the provisions of the NOTICE Act. Under the NOTICE Act, hospitals and CAHs must deliver the Medicare Outpatient Observation Notice to any member who receives observation services as an outpatient for more than 24 hours. Details for the NOTICE Act Requirements are [online](#).

CREDENTIALING

All practitioner and organizational applicants to HealthSpring must meet basic eligibility requirements and complete the credentialing process prior to becoming an in-network provider. These requirements are the same whether the provider is credentialed by HealthSpring, or another entity delegated by HealthSpring to credential Medicare Advantage network providers. HealthSpring credentialing standards and processes are designed to comply with CMS regulations and applicable laws.

HealthSpring does not discriminate in terms of participation or reimbursement, or based on the population of members serviced, against any health care provider who is acting within the scope of their license or certification under state law. To participate in the HealthSpring network, providers undergo a screening process before a contract can be extended to them.

Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied network participation with HealthSpring. No provider can be assigned a HealthSpring effective date, be included in a provider directory or have members assigned without completing the credentialing and peer review process. All providers who have been initially approved for participation are required to be recredentialed at least once every three years (every 36 months) to maintain participation status.

Providers and Organizational Network Selection Criteria

Providers

We utilize specific selection criteria to ensure that providers who apply to participate in the HealthSpring network meet basic credentialing and contracting standards. At minimum these include, but are not limited to:

- Holds appropriate, current and unrestricted licensure in the state of practice as required by state and federal entities
- Holds a current, valid and unrestricted federal Drug Enforcement Agency and state controlled-

- substance certificate, as applicable
- Is board certified or has completed appropriate and verifiable training in the requested practice specialty
- Has and maintains malpractice insurance, unless otherwise mandated by state or federal laws
- Has an NPI number
- Has not been excluded, suspended, precluded and/or disqualified from participating in any Medicare, Medicaid or other government health-related program
- Is not currently opted out of Medicare
- Has admitting privileges, as applicable

Application process

Complete and submit a Network Interest form. The Network Interest form is at HealthSpring.com/Providers > Working With Us. We will review each provider for eligibility, current contract status and network need. If approved for a contract, we will send a contract (unless a current group agreement already exists) and a Form W-9 that must be completed and signed. Providers must register with CAQH and ensure that all information contained in their CAQH profile is current, including the attestation signature date, and that they have given HealthSpring permission to access the CAQH information.

All credentialing applications must contain the following information to be considered complete:

- All current and active state medical licenses, Drug Enforcement Agency certificates and state-controlled substance certificate, as applicable
- Evidence of current malpractice insurance, including the effective and expiration dates of the policy and term limits
- Five years of work history documented in a month/year format either on the application or on a current curriculum vitae. Explanations are required for any gaps exceeding six months
- Sufficient additional information and explanations if any of the professional disclosure questions are answered "yes" on the application
- Appropriate clinical detail for all pending malpractice cases or those that resulted in a settlement or other financial payment within the last five years
- Current and complete hospital affiliation information on the application. If there are no hospital admitting privileges and the specialty warrants them, a letter detailing the alternate coverage arrangements or the name of the alternate admitting physician must be provided
- Signed and dated application
- Once the credentialing process is complete, we'll send a welcome letter that contains your participation effective date. Be advised that any requests for payment for services rendered to a HealthSpring member prior to your participation effective date shall be denied.

Provider rights:

You have the right to:

- Review information obtained from any outside source to evaluate their credentialing application with the exception of references, recommendations or other peer-review protected information
- Correct erroneous information when information obtained during the credentialing process varies substantially from the information you submitted. In these instances, the Credentialing department will notify you in writing of the discrepancy within 30 days of receipt of the information. You must submit a written response and any supporting documentation to the Credentialing department to either correct or dispute the alleged variation in your application information within 30 days of notification.

- Be informed of the status of your application upon request. You may request the status of the application by contacting the email on the network interest form.

When assessing organizational providers for participation in the HealthSpring network, we criteria including but not limited to:

- Is in good standing with all state and federal regulatory bodies
- Has been reviewed and approved by an accrediting body deemed by Medicare or recognized by HealthSpring, and/or has received a passing score on the HealthSpring credentialing site review
- If not accredited, has provided a copy of a survey conducted by a state or federal agency within the 36 months prior to application submission that contains the corrective action plan for any identified deficiencies, as well as proof of state or federal acceptance of the corrective action and/or current compliance with Medicare/Medicaid program requirements. Organizations that are not accredited or have not been surveyed by a state or federal regulatory body within the last 36 months may be subject to a health plan conducted site audit.
- Maintains current professional and general liability insurance, as applicable
- Has not been excluded, precluded, suspended and/or disqualified from participating in any Medicare, Medicaid or other government health-related program
- Is currently enrolled in and has active status with Medicare, including any subsidiaries and/or additional NPI numbers the organization may utilize

Organizational provider

Application process

- Complete an Ancillary/Facility Credentialing Application with a signed and dated attestation.
- Provide sufficient additional information and explanations if any of the disclosure questions are answered "yes" on the application.
- All credentialing applications must contain the following information to be considered complete:
 - All applicable state and federal licenses (e.g., facility license, Drug Enforcement Agency certificate, CLIA certificate, pharmacy license)
 - Proof of current professional and general liability insurance, as applicable
 - Proof of Medicare enrollment, per site, if submitting multiple locations
 - Proof of current accreditation, if accredited

Current accreditation status is also required for durable medical equipment, prosthetic/orthotics and non-hospital based high-tech radiology providers who perform MRIs, CTs and/or nuclear/PET studies

- If not accredited, a copy of any state or CMS site surveys that occurred within the last three years, including evidence that the organization successfully remediated any deficiencies identified during the survey

Organizational site surveys

As part of the initial assessment, an on-site review will be required of all hospitals, skilled nursing facilities, freestanding surgical centers, home health agencies and inpatient, residential or ambulatory behavioral health or substance use disorder centers that do not hold an acceptable accreditation status or cannot provide evidence of successful completion of a recent state or CMS site survey. Any organizational provider may also be subject to a site survey, as warranted, subsequent to the receipt of a complaint.

Credentialing and Recredentialing Process

The HealthSpring Credentialing department conducts primary and secondary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, Medicare status and malpractice history by querying the National Practitioner Data Bank. Once credentialing is completed and the applicant approved, we will notify the provider in writing of their participation effective date.

Facilities shall immediately restrict any individual health care provider under its control or supervision (i.e., any employee or subcontractor) from rendering services to members if the provider ceases to meet the licensing or certification requirements or other professional standards required. Facilities must notify HealthSpring within 30 days of any changes in employees', subcontractors' and/or independent contractors' accreditation, certification, licensure and/or registration status.

To maintain participation status, all providers are required to recredential at least every three years (every 36 months). Information obtained during the initial credentialing process will be updated and verified again, as required. Providers who fail to return recredentialing information will be notified in writing of their termination from the network.

Credentialing Committee and Peer Review

All initial applicants and recredentialed providers are subject to a peer review process prior to approval or re-approval as an in-network provider. Providers who meet all the acceptance criteria may be approved by the medical director. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration.

The Credentialing Committee comprises contracted primary care and specialty providers and has the authority to approve or deny a provider's appointment status. All required credentialing information and verifications must be completed and less than 120 days old at the time of presentation to the medical director or the Credentialing Committee for approval.

Providers must be contracted with and credentialed by HealthSpring according to the following guidelines:

Provider: New to plan and not previously credentialed	
Status	Action
Practicing in a solo practice	Requires a signed contract and initial credentialing
Joining an in-network group practice	Requires initial credentialing

Provider: Already participating and credentialed

Status	Action
Leaving a group practice to begin a solo practice	Does not require credentialing; however, a new contract is required, and the previous group practice affiliation is terminated
Leaving an in-network group practice to join another participating group practice	Does not require credentialing yet; however, the group practice affiliation will be amended
Leaving an in-network group practice to join an out-of-network group practice	The provider's participation is terminated unless the out-of-network group signs a contract with HealthSpring. Credentialing is still valid until the recredentialing due date.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of the effective date or dates of their participation in the HealthSpring Medicare Advantage HMO, PPO or HMO/PPO network. Providers are advised to not see HealthSpring members until they receive this notification in writing. Applicants who are denied by the Credentialing Committee will be notified in writing within 30 days of the decision detailing the reason or reasons for the denial, unless local state or federal laws require a different time frame.

Confidentiality of Credentialing Information

All information obtained during the credentialing and recredentialing process is considered confidential and is handled and stored in a confidential and secure manner as required by law and regulatory agencies. Confidential provider credentialing and recredentialing information will not be disclosed to any person or any entity except with the written permission of the provider or as otherwise permitted or required by law.

Nondiscrimination in the Decision-Making Process

The HealthSpring credentialing program is compliant with all guidelines from the NCQA, CMS and state regulations, as applicable. Through the universal application of specific assessment criteria, HealthSpring ensures fair and impartial decision-making in the credentialing process and does not make credentialing decisions based on an applicant's race, color, national origin, sex, age or disability, or due to the type of members or procedures in which the provider specializes.

PROVIDER INFORMATION, RIGHTS AND RESPONSIBILITIES

Access and Availability Standards for Providers

A PCP must:

- Have their primary office open to receive HealthSpring members at least 20 hours per week
- Ensure coverage is available 24 hours a day, seven days a week, when medically necessary
- Be able to schedule appointments for HealthSpring members at least two months in advance of the appointment
- Arrange for coverage during absences with another HealthSpring Medicare Advantage in-network provider as agreed upon in their provider agreement

Primary care access standards	
Appointment type	Access standard
Urgent/emergency	Immediately
Nonurgent/nonemergency	Within seven business days
Routine and preventive	Within 30 business days
On-call response (after hours)	Not to exceed one hour in the event of an emergency
Waiting time in office	15 minutes or less

Specialist access standards	
Appointment type	Access standard
Urgent/emergency	Immediately
Nonurgent/nonemergency	Within seven business days
Elective	Within 30 business days
High index of suspicion of malignancy	Less than seven days
Waiting time in office	15 minutes or less

Behavioral health access standards	
Appointment type	Access standard
Emergency	Immediately
Urgent	Immediately
Routine	Within seven business days

After-Hours Access Standards

All HealthSpring in-network providers must return telephone calls related to medical issues. Emergency calls must be returned within 60 minutes of receipt of the phone call. Nonemergency calls should be returned within a 24-hour time period. A reliable 24-hours-a-day, 365-days-a-year answering service with a beeper or paging system and on-call coverage arranged with another in-network provider of the same specialty is preferred. Provider answering machines should direct members to the nearest emergency room in the case a provider, office staff or live party is not available to assist a member after hours.

HealthSpring conducts a yearly survey to monitor providers' access and availability compliance. The survey is conducted through a telephonic outreach to provider offices by a contracted vendor. Surveyors will require office staff to answer questions regarding appointment availability, physician accessibility and after-hours care. In addition, calls are made after hours to ensure that all answering services and answering machines have the appropriate messaging or after-hours physician information for members.

Please ensure that your office staff are available and trained to answer access and availability questions, and assist members with their routine, urgent and emergency care needs. HealthSpring will notify you in writing if your office failed to meet any of the access and availability standards during the survey. If a grievance is received regarding access and availability for your office, a HealthSpring representative will contact your office directly.

Changes in Address or Other Practice Information

Provider directory requirements

To be included in provider directories or any other member communications, providers must be fully credentialed and contracted. Directory specialty designations must be commensurate with the education, training, board certification and the specialty or specialties verified and approved by the credentialing process. Any requests for changes or updates to the specialty information in the directory will only be approved once validated through the credentialing process.

CMS demographic verification requirements

CMS requires all MAOs like HealthSpring to outreach to contracted providers on a quarterly basis to verify providers' demographic data published in the HealthSpring provider directories. CMS also requires MAOs to update the provider directories within 30 days of receipt of new or revised demographic information.

The accuracy of our directories directly impacts our members. We take this compliance requirement seriously and expect that you will cooperate fully with the attestation and validation process.

HealthSpring utilizes CAQH to outreach quarterly to in-network providers to verify their demographic data. For all other provider types, HealthSpring outreaches via mail and gives instructions on how to complete the quarterly attestation process. As an in-network provider you are required to comply with the outreach request and supply updated information within the allotted time frame. If we do not receive a response, you may be suppressed from our provider directory and/or be subject to other action.

Suppression from the directory means that members and other providers will not be able to view you as a participating provider in the HealthSpring networks. If you were removed from the directory and you are a provider, visit the CAQH website to update and attest to your demographic information. If you are a facility or ancillary provider, submit your attestation by visiting the Provider Network Verification System web page, HSProviderDataValidation.com.

If there are changes to your locations, phone numbers or any other demographic information, it is important to notify us within seven days of the change. Do not wait for the quarterly update. If you are an individual provider, log in to the CAQH ProView website (CAQH.ProView.org) to make the updates. If you are a facility or ancillary provider, visit HSProviderDataValidation.com to make the updates.

Plan notification requirements for providers

Participating providers must provide written notice to HealthSpring no less than 90 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter. The following is a list of changes that you must report to HealthSpring by contacting Provider Relations or Provider Customer Service:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Providers joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers or acquisitions

When your information changes, sign in to the [CAQH Provider Data Portal](#) and update your information as

soon as possible. If you have questions, call CAQH at 888-600-9802 or refer to their [help page](#).

Provider termination

When a provider is terminated or leaves the network, CMS requires HealthSpring to make a good faith effort to provide written notice to impacted members at least 30 days in advance for contract terminations that involve specialty types other than primary care or behavioral health and 45 calendar days in advance for primary care or behavioral health providers. Providing advance notice of network changes that affect the member helps ensure continuity of care for those impacted. This includes members who are seen regularly by the provider, have scheduled services with the provider or have received treatment or services from the provider within the past three years for PCPs and behavioral health specialties and within 90 calendar days for most other specialties.

Providers must provide advance written notice to HealthSpring (the time frame may vary based on a provider's network participation agreement) prior to terminating their agreement or leaving the network (due to retirement, office closure, moving out of the area, etc.). Refer to your participation agreement for termination notification requirements.

If you choose to leave the HealthSpring network, we urge you to inform your patients as early as possible to ensure a smooth transition. When possible, providers may discuss a suitable replacement PCP with their patients, who may then call HealthSpring Customer Service to make the change. If they do not select a new PCP, HealthSpring will assign a new one to them.

Administrative, medical and reimbursement policy changes

From time to time, HealthSpring may amend, alter or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards and modification of covered services. Specific HealthSpring policies and procedures may be obtained by calling HealthSpring Provider Customer Service at **800-230-6138**.

HealthSpring will communicate policy changes using a variety of methods including, but not limited to:

- Annual provider manual updates
- Letter
- Fax
- Email
- Provider newsletters
- Website updates

Providers are responsible for the review and inclusion of policy updates in the provider manual, periodically checking the HealthSpring website for updates and complying with these changes upon receipt of these notices or otherwise becoming aware or informed of such changes.

Communication Between Providers

- The PCP should share relevant clinical information about the member's care with the specialist
- In turn, the specialist must provide the PCP with timely updates about their visit with the member
- The PCP is responsible for documenting their review of any reports, labs or diagnostic tests received from a specialist in the member's medical record
- As a best practice, it is recommended to obtain a release of information from the member on their initial visit. This release allows the exchange of documents between the PCP, specialists and behavioral health practitioners as applicable. It also ensures that updates can be shared when there is a clinical need during the course of treatment or upon its completion.

A Provider's Role and Responsibilities

PCP role and responsibilities

HealthSpring recognizes family medicine, general practice, geriatric medicine and internal medicine physicians as PCPs. In addition, HealthSpring may recognize infectious disease physicians as PCPs for members who may require a specialized physician to manage their specific health care needs.

All contracted, credentialed providers who participate in the HealthSpring network are listed in the region-appropriate provider directory, which is provided to members and made available to the public via the [online provider directory](#) at HealthSpring.com.

HealthSpring HMO members must select a HealthSpring-participating PCP at the time of enrollment. PCP selection is not required for PPO members, but it is recommended. The PCP is responsible for managing all the health care needs of a HealthSpring member as follows:

- Ensure they receive treatment as frequently as needed based on their condition
- Develop an individualized treatment plan
- Submit accurate and timely claims and encounter information for clinical care coordination
- Comply with prior authorization and referral procedures, as applicable
- Make referrals to appropriate HealthSpring participating providers
- Comply with HealthSpring quality management and utilization management programs
- Conduct the HealthSpring 360 Annual Wellness Exam, an important benefit for our Medicare Advantage members.
- Use appropriate designated ancillary providers
- Comply with emergency care procedures
- Comply with HealthSpring access and availability standards as outlined in this manual, including for after-hours care
- Bill HealthSpring using Form CMS-1500 or electronically in accordance with HealthSpring billing procedures
- Ensure that when billing for services, coding is specific enough to accurately capture the acuity and complexity of a member's condition and is supported by proper documentation in the medical record
- Comply with preventive screening and clinical guidelines
- Adhere to HealthSpring medical record standards as outlined in this manual

PCP's right to request member assignment to a different PCP (HMO only)

HealthSpring in-network PCPs have a limited right to request the reassignment of a member to a different PCP. Such requests cannot be based solely on the member filing of a grievance, appeal or the request for a secondary review or other action. However, a provider may request the reassignment of a member to another provider under the following circumstances related to the member's behavior:

- Fraudulent use of services or benefits
- Disruptive, unruly, threatening or uncooperative behavior that seriously impairs the ability of HealthSpring or the provider to deliver services to the member or to other members. This applies only if the behavior is not attributable to a physical or behavioral health condition.
- Threats of physical harm to a provider or office staff
- Nonpayment of required copayment(s) for services rendered

- Receipt of prescription medications or health services in a quantity or manner not medically beneficial or not medically necessary
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan
- Steadfast refusal to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow HealthSpring to coordinate treatment of the underlying medical condition)
- Other behavior that results in serious disruption of the member-physician relationship

The provider should make reasonable efforts to address the member behavior that is negatively impacting the member-physician relationship. These efforts may include education, counseling and, if medically indicated, coordination with an appropriate specialist.

Procedure

- If the member's behavior cannot be resolved through reasonable efforts and the PCP determines that the member-physician relationship has been irreparably harmed, the PCP must complete the **Physician Notice to Discharge a Member from Panel** form and submit it to the number on the form, including detailed information and supporting documentation to justify their decision. The form can be accessed at Healthspring.com/Providers > Working With Us.
- HealthSpring will review the issue and document all actions taken by the PCP and HealthSpring to resolve the situation, which may involve member education, counseling, or reassignment. A HealthSpring in-network PCP is not permitted to request a member's reassignment based on an adverse change in the member's health status or utilization of medically necessary services for treating their condition.
- The PCP is required to send the member a notice informing them of the decision to terminate the member-physician relationship. The notice must be sent at least 30 calendar days in advance of the member's discharge from the practice.
- The PCP is required to continue providing care for the member for at least 30 to 45 days, or longer if necessary, to allow the member sufficient time to select a new PCP and be reassigned to one.
- The PCP must transfer a copy of the member's medical records to the new PCP at no cost and cooperate with the new PCP to ensure a smooth transition of care, including providing relevant information about the member's treatment.
- If the member requests a change in PCP for any reason, the new PCP selection will take effect on the first day of the month following the receipt of the request, unless circumstances necessitate an immediate change.

Advanced Practice Practitioners (Nurse Practitioners, Physician Assistants, etc.)

HealthSpring does not list Advanced Practice Practitioners as Primary Care Providers unless the provider is practicing in a designated shortage area for PCPs, per the [Health Resources and Services Administration](#).

Specialist role and responsibilities

Each HealthSpring member is entitled to see a specialist for certain services necessary to treat a specific health condition. The specialist is responsible for managing all aspects of the HealthSpring member's health care needs as follows:

- Provide specialty health care services to members as needed
- Collaborate with the member's PCP to enhance continuity of health care and appropriate treatment
- Provide consultative and follow-up reports to the referring physician in a timely manner
- Comply with access and availability standards as outlined in this manual, including for after-hours care
- Comply with prior authorization and referral process, as applicable
- Comply with HealthSpring quality management and utilization management programs
- Bill HealthSpring using Form CMS-1500 or electronically in accordance with HealthSpring billing procedures
- Ensure that when billing for services, coding is specific enough to accurately capture the acuity and complexity of a member's condition and is supported by proper documentation in the medical record
- Refer members to appropriate in-network providers
- Submit encounter information to HealthSpring accurately and in a timely manner
- Adhere to HealthSpring medical record standards as outlined below

Medical Records

HealthSpring requires the following items to be in a member's medical records:

- Identifying information of the member
- Identification of all providers participating in the member's care and information on services furnished by these providers
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses and treatment plans
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Information on allergies and adverse reactions (or a notation that the member has no known allergies or history of adverse reactions)
- Information on advance directives
- Past medical history, physical examinations, necessary treatments and possible risk factors for the member relevant to the particular treatment

BEHAVIORAL HEALTH

Responsibilities of the PCP

PCPs can participate in the identification and treatment of their member's behavioral health needs. A PCPs' responsibilities include:

- Screening and early identification of behavioral health and substance use disorders
- Treating members with behavioral health care needs within the scope of their practice and according to established clinical practice guidelines. These can be members with comorbid physical and minor behavioral health problems, or those who require treatment but refuse to access a behavioral health or substance use disorder provider.
- Consulting with or making referrals for members with complex behavioral health needs, or those not responding to treatment
- Communicating with other physical and behavioral health providers on a regular basis
- Submitting claims with appropriate medical and behavioral health diagnosis codes. If you have questions,

go to [HealthSpring.com/Providers](https://www.healthspring.com/providers) > Coverage and Claims.

- Coordinating care with the patient's behavioral health practitioner when the patient first enters treatment, as well as sending subsequent updates when there is a clinical indication and when the patient completes treatment

Access to Care

Members may access behavioral health services as needed.

- Members may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Members may access their PCP to discuss their behavioral health care needs or concerns, receive treatment that is within their PCP's scope of practice and request a referral to a behavioral health practitioner. Referrals, however, are not required to receive most in-network behavioral health or substance use disorder services.
- Members and providers can call HealthSpring Behavioral Health to receive orientation on how to access behavioral health services, provider information and prior authorizations at **800-453-4464**.

Medical Record Documentation

When requesting prior authorization for specific services or billing for services provided, behavioral health providers must use the current Diagnostic and Statistical Manual of Mental Disorders multi-axial classification system and document a complete diagnosis. The provision of behavioral health services requires progress note documentation that corresponds with the day of treatment, the development of a treatment plan, the outcome of treatment and the discharge plan, as applicable, for the member in treatment.

Continuity of Care for Behavioral Health

Continuity of care is essential to maintaining member stability. Behavioral health providers and PCPs, as applicable, are required to:

- Evaluate the member if they were hospitalized for a behavioral health condition within seven days post-discharge
- Provide members receiving care with contact information for any emergency or urgent matter arising that necessitates communication between the member and the provider
- Evaluate member needs when the member is in acute distress
- Communicate with the member's other health care providers
- Identify members who need a follow-up visit and refer them to HealthSpring behavioral health-focused case management program, as necessary
- Discuss cases, as needed, with a peer reviewer
- Request prior authorization for a member in an active course of treatment with an out-of-network practitioner

HealthSpring monitors the continuity and coordination of care for behavioral health members by:

- Following up after emergency department visit for substance use.
- Following up after hospitalization for mental illness.
- Following up after high-intensity care for substance use disorder.
- Following up after emergency department visit for mental illness.
- Initiating and engaging substance use disorder treatment.
- Using the provider coordination-of-care survey, which measures communication between behavioral

health providers and PCPs, including accuracy, sufficiency, timeliness, clarity, and frequency.

- Monitoring antidepressant medication-compliance rates.
- Ensuring the appropriate use of psychotropic medications.
- Ensuring members with depression are accurately assessed, diagnosed and remain on medication for a minimum of 84 days.
- Monitoring diabetes in members with diabetes and schizophrenia.
- Ensuring Initiation and Engagement of Substance Use Disorder

Utilization Management for Behavioral Health

The Clinical Operations department includes licensed health care providers and board-certified psychiatrists who coordinate behavioral health care services to ensure appropriate utilization of behavioral health and substance use disorder treatment resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate and cost-effective manner for the members.

The Utilization Management staff base their utilization management decisions on the clinical needs of members, the member's benefit plan, well established clinical decision-making support tools, the appropriateness of care, CMS guidelines, health care objectives, clinical criteria based on widely used treatment guidelines or clinical literature in the context of clinical information provided by both the provider and the member, as well as any other relevant information. For requests for behavioral health services requiring prior authorization, HealthSpring will either approve the request or issue a notice of denial. A notice of denial will be issued if the requested services are determined to be either medically unnecessary or not covered by Medicare.

Contract Exclusions for Behavioral Health

HealthSpring retains the right to deliver certain services through a vendor or contractor, unless your contract specifically dictates otherwise. If HealthSpring elects to deliver certain services that you are currently contracted to provide through a vendor or contractor, you will be provided a minimum of 30 days' advance notice, and the terms of your contract will be honored during that notice period. After the notification period, HealthSpring retains the right to discontinue reimbursement for services provided by the vendor or contractor.

PHARMACY

Pharmacy Prescription Benefit Part D Drug Formulary

For detailed information regarding Part D drugs, their utilization management requirements (prior authorization, step therapy, quantity limits), non-extended day supply limitations, any plan year negative changes and most recent plan formularies, go to [HealthSpring.com/Providers](https://www.healthspring.com/Providers) > Pharmacy.

HealthSpring utilizes a customized classification system defined by the Pharmacy and Therapeutics Committee to develop Part D drug formularies that include drug categories and classes covering a variety of disease states. Each category must include at least two drugs, unless only one drug is available for a particular category or class.

HealthSpring includes all, or substantially all, drugs in protected classes, as defined by CMS. The P&T Committee reviews all formularies for clinical appropriateness, including the utilization management edits placed on formulary products. HealthSpring submits all formulary changes to CMS according to the timelines specified by CMS.

A Part D drug is a drug that meets the following criteria:

- Dispensed only by prescription
- Approved by the FDA
- Used and sold in the U.S.
- Used for a medically accepted indication

- Medically accepted indication is defined as both the uses approved by the FDA and off-label uses supported by the CMS recognized compendia, Micromedex and American Hospital Formulary Service Drug Information. On their own, uses described by clinical guidelines or peer-reviewed literature are insufficient to establish a medically accepted indication.
- NCCN, Clinical Pharmacology and Lexicomp, as well as peer-reviewed literature, are also used to determine medically accepted indications for drugs or biologicals used off-label in an anti-cancer chemotherapeutic regimen.
- Includes prescription drugs, biologic products, vaccines that are reasonable and necessary for the prevention of illness, insulin and medical supplies associated with insulin that are not covered under Parts A or B (syringes, needles, alcohol, swabs, gauze and insulin delivery systems not otherwise covered under Medicare Part B)

Drugs excluded under Part D include the following:

- Drugs for which payment – as so prescribed or administered to an individual – is available for that individual under Part A or Part B
- Drugs or classes of drugs, or their medical uses, which are excluded from coverage or otherwise restricted under Medicare (except for smoking-cessation products)
- Drugs for anorexia, weight loss or weight gain
- Drugs to promote fertility
- Drugs for cosmetic purposes and hair growth
- Drugs for symptomatic relief of coughs and colds
- Vitamins and minerals (except for prenatal vitamins and fluoride preparations)
- Nonprescription drugs
- Outpatient prescriptions for which manufacturers require the purchase of associated tests or monitoring services as a condition for getting the prescription (manufacturer tying arrangements)
- Agents used for treatment of sexual or erectile dysfunction (except when prescribed for other FDA-approved indications, such as pulmonary hypertension)

Part D 100 Days' Supply

HealthSpring has expanded the Part D 100 Days' Supply option to all HMO enhanced alternative plans. Members can fill prescription drugs for formulary drugs on Tiers 1 through 4 at both preferred and standard retail and/or mail order pharmacies. Members will pay the same cost-share for a 100-day supply as a 90-day supply.

The Part D 100 Days' Supply benefit does not automatically apply to all 90-day prescriptions. Providers must prescribe up to a 100-day supply for eligible Tier 1 through 4 drugs.

Defined standard, PPO and Primary plans (TN) are excluded from the Part D 100 Days' Supply benefit.

Part D Utilization Management

HealthSpring formularies include utilization management requirements such as prior authorization, step therapy and quantity limits. To access the HealthSpring Medicare Advantage Part D utilization management requirements, go to [HealthSpring.com/Providers](https://www.healthspring.com/providers) > Pharmacy.

Prior authorization

For certain prescription drugs, HealthSpring requires members or their provider to obtain prior authorization before the prescription will be covered. This is needed to determine if a drug should be covered under the member's

Medicare Part B or Part D benefit. Another common reason prior authorization may be required is to ensure that a drug is being used for a medically accepted or Part D-allowed indication, as defined above. Some drugs may have more detailed prior authorization criteria and require submission of medical information such as lab results and current and/or past medication history.

Providers can submit prior authorization requests electronically via their electronic health record (using [CoverMyMeds](#) or [Surescripts](#)®), or by using the Surescripts Prior Authorization Portal ([Surescripts.com > Prior Authorization Portal](#)) or forms available at [HealthSpring.com](#). If you are unable to use the electronic prior authorization function, contact Provider Customer Service by phone, fax or mail.

Coverage determination filing

A coverage determination is any decision made by or on behalf of a Part D plan sponsor (such as HealthSpring) regarding payment or benefits to which a member believes they are entitled. A coverage determination may be received orally or in writing from the member (or appointed representative) or the member’s prescribing physician.

Coverage determination outcome notification time frames

Request type	Outcome notification method	Time frame
Standard	Phone, fax or U.S. mail	No later than 72 hours after the initial request was received or receipt of the supporting statement
Urgent	Phone, fax or U.S. mail	No later than 24 hours after the initial request was received or receipt of the supporting statement

Note that if the request is regarding payment for a prescription drug the member already received, an expedited request is not permitted; members can submit an [Enrollee Prescription Drug Claim Form](#) to request reimbursement. HealthSpring will provide a decision and written coverage determination notice no later than 14 calendar days from the date the request was received.

Information provided for denied and approved coverage determinations

Coverage determination	Information provided
Denied	<ul style="list-style-type: none"> The specific reason for the denial, taking into account the member’s medical condition, disabilities, and special language requirements, if any Information regarding the right to appoint a representative to file an appeal on the member’s behalf A description of both the standard and expedited redetermination processes and time frames, including conditions for obtaining an expedited redetermination and the appeals process
Approved	<ul style="list-style-type: none"> The duration of an approval Limitations associated with an approval and any coverage rules applicable to subsequent refills

Redetermination or appeal filing

A Part D appeal, or redetermination, must be filed within 60 calendar days from the date that appears on

the coverage determination denial letter. HealthSpring can receive it orally or in writing from a member, a member's representative or a member's prescribing physician or other physician.

Part D appeal outcome notification time frames

Appeal type	Outcome notification method	Time frame
Standard	Phone, fax or U.S. mail	No later than seven calendar days after the appeal was received
Expedited	Phone, fax or U.S. mail	No later than 72 hours after the appeal was received

Expedited appeals may be requested in situations where applying the standard time frame could seriously jeopardize the member's life, health or ability to regain maximum function. Refer to [HealthSpring.com](https://www.healthspring.com) > Member Resources > [Medicare Appeals Process](#).

If the request is regarding payment for a prescription drug the member already received, an expedited appeal is not permitted and members can submit an [Enrollee Prescription Drug Claim Form](#) to request reimbursement. Such requests must be received in writing. HealthSpring will provide a decision and written coverage determination notice no later than 14 calendar days from the date the request was received.

Part D appeals contact information:

- Phone: 866-845-6962
- Fax: 866-593-4482

Step therapy

For a select group of drugs, HealthSpring requires the member to first try and fail certain drugs or drug classes to treat their medical condition before covering another drug for that condition.

Quantity limits

For a select group of drugs, HealthSpring limits the amount of the drug that will be covered without prior approval.

Pharmacy Quality Improvement

The HealthSpring Pharmacy Quality department maintains clinical programs that meet or exceed CMS and NCQA standards, drive improvements in CMS Star ratings and Healthcare Effectiveness Data and Information Set (HEDIS®) metrics and continually strive to improve quality of pharmacy care and prevent under- or overutilization of medication therapy among our members. These programs include, but are not limited to:

- Medication therapy management
- Opioid drug management
- High risk medication review programs
- Clinical optimization pharmacist program
- Population health: Pharmacy and medical integration
- Drug utilization review
- Pharmacy Stars support

A description of each program follows.

Medication therapy management program

The HealthSpring medication therapy management program is designed to help improve medication therapy outcomes by identifying gaps in care, addressing adherence and recognizing potential cost-savings opportunities. It is designed for members who satisfy certain CMS criteria.

Eligible members are automatically enrolled into the program and sent a welcome letter encouraging them to call to complete their comprehensive medication review before their annual wellness visit. Members who call speak with a clinical pharmacist who will review with them their prescriptions, over-the-counter medications, herbal therapies and dietary supplements. Any potential drug therapy problems identified during the call will be sent to the prescribing provider and/or PCP by mail or fax, along with an updated list of the member's medication history through the previous four months. The member will also receive an individualized letter that includes their personal medication record of all medications discussed and a medication action plan.

In addition to this review, members may also receive quarterly targeted medication reviews. These reviews are generated using the medication therapy management software to review for specific drug therapy problems. If any drug therapy programs are identified, a letter may be mailed or faxed to the prescribing provider and/or PCP.

There is no additional cost for participation in the medication therapy management program.

If you have patients with HealthSpring plans who are eligible for the medication therapy management program, please refer them by calling **800-625-9432** so that they may complete their annual comprehensive medication review. For more information, go to [HealthSpring.com](https://www.healthspring.com) > Member Resources: [Medication Therapy Management](#).

Opioid drug management program

The HealthSpring opioid drug management program is designed to identify patterns of inappropriate opioid utilization with the goal of enhancing member safety through improved medication use. Quarterly reports are generated by CMS, using criteria that identifies members who may be potentially at risk of opioid overutilization. Members are identified either based on their number of prescribers, number of pharmacies, calculated morphine milligram equivalent (MME) per day or having a history of an opioid-related overdose and recent opioid utilization. Individuals who have cancer-related pain or sickle cell disease, are receiving hospice or palliative care, or are a resident of a long-term care facility are excluded from the program.

Clinical staff review claims data of all identified members who meet the established criteria and determine whether further investigation with prescribers is warranted. If intervention is deemed appropriate, clinical staff will fax written notification letters to the prescribers involved in the member's care requesting information pertaining to the medical necessity and safety of the current opioid regimen. HealthSpring clinical staff may reach out to discuss the case with the member's opioid prescribers in an attempt to reach a consensus regarding the member's opioid regimen.

If clinical staff is able to engage with prescribers, then action will be taken based on an agreed-upon plan. In the most severe cases, clinical staff may collaborate with the prescribers to implement member-specific limitations to assist with control of inappropriate utilization or overutilization of opioid medications. The limitations may apply to opioid and/or benzodiazepine medications and may require members to use only selected pharmacies or prescribers for selected medications or limit the amount of opioid or benzodiazepine medication covered by HealthSpring. If HealthSpring does not receive a response from the prescribers, despite multiple outreach attempts, then limitations may be invoked based on the decision of an internal, multidisciplinary team according to CMS requirements.

As part of our ongoing partnership with providers to reduce unnecessary use and diversion of controlled substances, HealthSpring encourages prescribers and pharmacists to fully utilize their state's prescription drug monitoring program. You can locate [your state's program online](#).

High-risk medication review programs

The HealthSpring Pharmacy Quality Improvement team provides comprehensive medication reviews for high-risk Medicare Advantage members who have potential medication-related issues or concerns. The PQI team works collaboratively with the HealthSpring Care Management department to identify members who may benefit from a medication review, including members recently discharged from inpatient care and members with other potential medication-related issues or concerns. For members not enrolled in care management, the PQI team proactively identifies and completes comprehensive medication reviews for high-risk members who are likely to benefit from a medication review. The program is designed to help optimize medication treatment, improve medication adherence and management, and assist with medication affordability.

The team's clinical pharmacists partner with HealthSpring care managers (or member, if no care manager is assigned) to provide recommendations. Recommendations to resolve potential drug therapy problems are also communicated to the member's providers via fax.

These programs support CMS requirements for HealthSpring's SNP Model of Care (MOC) as well as gap closure for the NCQA HEDIS measures Transitions of Care – Medication Reconciliation Post-Discharge and the Care for Older Adults – Medication Review.

Clinical optimization pharmacist program

The HealthSpring Clinical Optimization Pharmacist team partners with select provider groups with a high volume of members to offer enhanced clinical support aimed at improving member and plan outcomes. Clinical optimization pharmacists work closely with members and their health care team to provide comprehensive support across various settings, including face-to-face, telephonic and virtual environments.

Clinical optimization pharmacists contribute to other pharmacy quality programs outlined in this manual, as well as additional targeted initiatives. All services provided by clinical optimization pharmacists are tailored specifically for their aligned provider groups and associated member populations.

Population health: Pharmacy and medical integration program

The HealthSpring Population Health Pharmacy team develops and coordinates initiatives to reduce medical and pharmacy costs, improve member health outcomes and increase pharmacy-related quality ratings. The team employs strategies to reduce access barriers associated with medication use and provides pertinent pharmacy benefits and services education to internal and external stakeholders, including health systems, providers and providers' office support staff.

Drug utilization review program

Drug utilization review is a structured, ongoing review of prescribing, dispensing and use of medication to identify potential drug therapy problems that could result in adverse drug events.

Retrospective drug utilization review evaluates prescription drug claims data (after the medications have been dispensed to the member).

Concurrent drug utilization review is typically performed at the point-of-sale, or point of distribution, by automated checks that are integrated into the pharmacy claims processing system (before the medications have been dispensed to the member).

HealthSpring clinical staff track and trend drug utilization review data on a monthly or quarterly basis. The types of drug therapy problems that are identified and addressed include, but are not limited to:

- Underutilization or failure to refill prescribed medications
- Drug-drug and drug-disease interactions
- Overutilization or duplicate therapy
- Opioid safety, including potential abuse or misuse
- Use of medications classified as high risk for use in the older population

The HealthSpring retrospective drug utilization review is conducted through various channels. HealthSpring clinical staff will alert prescribers of drug therapy problems through mail, fax or EHR integrated messaging solutions, where available.

The HealthSpring concurrent drug utilization program aligns with CMS requirements for opioid safety edits. Safety controls will be implemented at the point of sale, including “soft” and “hard” concurrent drug utilization edits, which will reject opioid claims that meet certain utilization criteria. The dispensing pharmacy may override a “soft” rejection by entering the appropriate pharmacy professional service codes upon consulting the prescriber and/or determining the safe and appropriate use of the medication. “Hard” rejections may not be overridden at the point of sale; to request coverage of the medications, a coverage determination must be initiated.

The current opioid concurrent drug utilization safety edits are listed below. They align with CMS guidance on required and recommended utilization management of opioid prescriptions.

- Opioid prescriptions are limited to a maximum of a one-month supply **or** a seven-day supply in opioid naïve members. HealthSpring defines “opioid naïve” as members who have not had an opioid medication filled within the past 108 days. This is a “hard” edit and will require a coverage determination for coverage under the member’s part D plan if a day supply exceeding these limits is needed. However, if the member meets a specific exemption (including not being truly opioid-naïve, in palliative care, has cancer, is in long-term care or has sickle cell anemia), the dispensing pharmacist may use PPS codes to override this “hard” rejection.
- Opioid prescriptions for members who have claims exceeding a total of 90 MMEs per day **and** have two or more opioid prescribers will receive a “soft” rejection at the point-of-sale. Coordination of care between the prescriber and the dispensing pharmacist is encouraged. Upon consulting the prescriber and receiving approval, the dispensing pharmacist may use PPS codes to override the “soft” rejection.
- Opioid prescriptions will “soft” reject at the point-of-sale if an interaction with a benzodiazepine from a different prescriber is detected. The dispensing pharmacist may override the denial with PPS codes if they consult with the prescriber, provide member counseling and/or determine that it is safe to dispense the medications.
- Opioid prescriptions for long-acting opioid medications will “soft” reject at the point of sale if a duplication of therapy is detected between two or more long-acting opioid medications. The dispensing pharmacist may override the denial with PPS codes if they consult with the prescriber, provide member counseling and/or determine that it is safe to dispense the opioid medications.

Pharmacy Stars Support Programs

HealthSpring has multiple programs to specifically support the following pharmacy-related Medicare Part C and D Star measures:

- Statin use in persons with diabetes
- Statin therapy for patients with cardiovascular disease
- Medication adherence for diabetes medications
- Medication adherence for hypertension (RAS antagonists)
- Medication adherence for cholesterol (statins)
- Concurrent use of opioids and benzodiazepines
- Use of multiple anticholinergic medications in older adults

Low-Income Subsidy Program

Overview

The federal Medicare Extra Help (or Low-Income Subsidy) program provides extra assistance with Medicare prescription drug costs for individuals who have limited income and resources. Although most members who are eligible for Extra Help benefits will automatically qualify for this program, there are many others who may qualify by applying for this valuable benefit. Many individuals may not know they are eligible. The Extra Help program has many benefits for qualified individuals, including:

- Low or no monthly Part D premiums
- Low or no initial Part D deductible
- Coverage in the donut hole or coverage gap
- Greatly reduced costs for prescription drugs that are covered by the Medicare Part D plan and/or 90-day supply of Medicare Part D covered drugs for the same cost as a 30-day supply (applies to most but not all members who qualify for Extra Help)

Eligibility

To be eligible for the Extra Help program, individuals must reside in one of the 50 states or the District of Columbia and meet certain income and resource limits. Resources include items like savings, stocks and money in checking and savings accounts, but will not include an individual's home or car. Income limits set by the federal government are used to determine eligibility for the Extra Help program and are based on the federal poverty level published by HHS.

Applying for Extra Help

Individuals with limited income and resources may qualify for Extra Help to reduce their out-of-pocket costs. Applying for Extra Help is easy. HealthSpring members can choose from the following options:

- Call the Social Security Administration: **800-772-1213** or **800-325-0778** (TTY); apply over the phone or request a paper application
- Apply online: [SSA.gov](https://ssa.gov) > Medicare > [Apply for Part D Extra Help](#)
- Call PremiumAssist (provided by Human Arc): **877-236-4471**
- Visit the Centauri Health Solutions website CentauriHS.com > Members & Patients > Eligibility & Enrollment Services: [Click here to see if you qualify.](#)

If an individual does not qualify for Extra Help, state programs may be available to help pay for prescription drug costs. HealthSpring encourages all members to inquire about these federal and state programs.

Pharmacy Networks

HealthSpring provides access to more than 62,000 network pharmacies throughout the country. This extensive network gives our members convenient access to many pharmacies in their area to choose for their unique

needs. Options range from large chain pharmacies to locally owned, independent retail pharmacies. Long-term care, home infusion, Indian Tribal Unit and mail order/home delivery pharmacy options are also available.

Preferred pharmacy network

There are also a large number of pharmacies in our preferred pharmacy network, including over 26,000 retail pharmacies across the U.S., that offer lower copayments on most prescriptions. Large national and regional chains in this network include Walgreens, Walmart and many grocery store pharmacies. The network also includes numerous local and independent pharmacies options.

To view the most up-to-date list of preferred pharmacies, visit [HealthSpring.com](https://www.healthspring.com) > Member Resources > [Provider and Pharmacy Directories](#). You can also link to the provider and pharmacy directories by region. Preferred pharmacies are identified with a grey-shaded box.

Members can choose to use a pharmacy in the standard or preferred network according to their needs, but only preferred pharmacies can offer reduced cost sharing on prescription drugs. This can often result in significant total savings over the course of a year, especially for members who take multiple prescription medications.

Home delivery

One of the most important ways to improve the health of your patients is to make sure they receive and take their medications as you prescribe.

Your patients can receive a three-month supply of their medications through mail order, making it easier for them to fill their prescriptions. Using preferred mail order pharmacy services may lower patient prescription costs and medication adherence – which can lead to lower health care utilization and total health care costs. Medication adherence is also associated with better health outcomes and decreased risk of hospitalization.

Express Scripts[®]

Express Scripts Pharmacy is the preferred home delivery pharmacy. HealthSpring members should first set up an account with Express Scripts to get their current prescriptions filled through home delivery. They can do this by calling Express Scripts at **877-860-0982** or registering online at [Express-Scripts.com](https://www.express-scripts.com) > [Register](#). Express Scripts will outreach to the provider for the prescriptions.

To request participation in the Express Scripts Pharmacy network, go to [ESIPROVIDER.COM](https://www.esiprovider.com).

Specialty pharmacies

Accredo by Evernorth[®]

Accredo by Evernorth is a specialty pharmacy that has a team of specialty-trained pharmacists and nurses who are available 24 hours a day, 365 days a year to help members with questions about their specialty medications. Accredo is ready to work with you and the member to help them receive the best possible care. To get started, call an Accredo patient care advocate at **877-860-0982**.

PROVIDER COMMUNICATIONS AND MARKETING

The information below is a general guideline to assist HealthSpring in-network providers who have contracted with multiple Medicare Advantage plans and accept Medicare fee-for-service members to determine what member outreach activities are permissible under CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering, or attempting to steer, an undecided potential enrollee toward a specific plan or limited

number of plans, based on the financial interest of the provider or agent. Providers should remain neutral parties when assisting members with enrollment decisions.

Providers can:

- Mail and call their patient panel to invite them to general educational events run by HealthSpring to learn about HealthSpring Medicare Advantage. This cannot be a sales or marketing meeting, and no sales or plan materials can be distributed. Sales representative business cards can be provided upon request.
- Have additional mailings (unlimited) to their patients about their participation status but must list all participating Medicare Advantage plans and not steer toward a specific plan. A letter may not quote specific plan benefits without the prior approval of CMS and the agreement of all plans listed.
- Notify their patients in a letter of a decision to participate in HealthSpring-sponsored programs
- Utilize a provider or member newsletter to communicate information to patients on a variety of subjects
- Provide objective information to their patients on specific plan formularies based on patients' medications and health care needs
- Refer their patients to other sources of information, such as the State Health Insurance Assistance Program, HealthSpring marketing representatives, state Medicaid or **800-Medicare** to assist them in learning about the plan and making a health care enrollment decision
- Display and distribute HealthSpring Medicare Advantage and HealthSpring Medicare Advantage Prescription Drug (MAPD) plan marketing materials in common areas of provider offices. The office must display or offer to display materials for all participating Medicare Advantage plans.
- Notify their patients of a provider's decision to participate exclusively in the HealthSpring Medicare Advantage network or the decision to close its panel for accepting patients with Original Medicare fee-for-service plans, if appropriate
- Display promotional and educational items with the HealthSpring logo. Note that promotional items cannot be displayed in areas where care is being delivered.
- Allow HealthSpring to have a room or space in provider offices completely separate from where patients are receiving care to provide members access to a HealthSpring sales representative

Providers cannot:

- Urge or steer their patients toward any specific plan or limited set of plans
- Accept or collect Medicare scope-of-appointment or enrollment applications
- Offer inducements to persuade members to enroll in a particular plan or organization
- Conduct health screenings for potential enrollees as a marketing activity
- Expect or accept compensation directly or indirectly from a plan for any marketing or enrollment activities
- Call patients who are disenrolling from the health plan to encourage reenrollment in a health plan

- Mail marketing materials to patients on behalf of a health plan
- Call patients to invite them to sales activities for a health plan
- Advertise using the HealthSpring name without the prior consent of HealthSpring.

Note: The information contained in this section should not be construed as legal advice. For the most current guidelines, go to [CMS Managed Care Marketing](#).

MEMBER INFORMATION, RIGHTS AND RESPONSIBILITIES

Member Information

When an in-network PCP elects to stop accepting new members, the provider's patient panel is considered closed. If an in-network PCP closes their patient panel, the decision to stop accepting new patients must be communicated to HealthSpring and must apply to all patients regardless of insurance coverage. Providers may not discriminate against HealthSpring members by closing their patient panels to HealthSpring members only, nor may they discriminate among HealthSpring members by closing their panel to certain product lines.

Providers who decide that they will no longer accept any new members must notify HealthSpring Network Management, in writing, at least 30 days before the date on which the member panel will be closed or the time frame specified in their contract.

Benefits and services

All HealthSpring members receive benefits and services as defined in their evidence of coverage. Each month, HealthSpring makes available to each participating PCP a list of their active members. The list includes the name of the plan in which the member enrolled, along with the member's demographic information.

Be aware that recently terminated members may appear on the list. See the [Member Eligibility Verification](#) section of this manual).

HealthSpring encourages its members to call their PCP to schedule appointments. However, if a HealthSpring member calls or comes to your office for an unscheduled nonemergency appointment, please attempt to accommodate the member and explain to them your office policy regarding appointments. If this problem persists, contact the HealthSpring Medicare Advantage Provider Customer Service.

Excluded services

Refer to a plan's specific explanation of coverage or call HealthSpring Provider Customer Service for assistance.

Emergency services and care after-hours

An emergency is defined as the sudden onset of a medical condition with acute symptoms and the member reasonably believes that the lack of immediate medical attention could result in:

- Permanently placing their health in jeopardy
- Serious impairments to body functions
- Serious or permanent dysfunction of any body organ or part. Refer to your agreement for the full definition of emergency services.

In the event of a perceived emergency, members have been instructed to first contact their PCP for medical advice. However, if the situation is of such a nature that it is life-threatening, members have been instructed to go immediately to the nearest emergency room.

Members who are unable to contact their PCP prior to treatment have been instructed to contact their PCP as soon as is medically possible or within 48 hours after receiving care. The PCP will be responsible for providing and arranging any necessary follow-up services.

For emergency services within the service area, the PCP is responsible for providing, directing or obtaining prior authorization for a member's emergency care. The PCP or their designee must be available 24 hours a day, 365 days a year to assist members needing emergency services. The hospital may attempt to contact the PCP for direction.

Members may have a copayment responsibility for outpatient emergency visits unless an admission results.

HealthSpring will reimburse out-of-network providers in accordance with CMS requirements for emergency services rendered to members if they become injured or ill while temporarily outside the plan's service area. Members may be responsible for a copayment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

Urgent care services

Urgent care services are for the treatment of symptoms that are non-life-threatening but that require immediate attention due to a member's unforeseen illness, injury or condition; it was not reasonable, given the circumstances, to obtain services through a HealthSpring Medicare Advantage in-network provider; and the member is either temporarily not in the HealthSpring Medicare Advantage service area or the HealthSpring Medicare Advantage provider network is temporarily unavailable or inaccessible. The member must first attempt to receive care from their PCP. HealthSpring will cover treatment at an in-network urgent care center without a referral.

Continuing or follow-up treatments

Except when rendered by the PCP, continuing or follow-up treatments – in or out of the service area – are not covered by HealthSpring Medicare Advantage HMO plans unless specifically authorized or approved by HealthSpring. Payment for covered benefits outside the service area is limited to medically necessary treatment required before the member can reasonably be transported to an in-network hospital or returned to the care of the PCP.

Member Rights

HealthSpring members have certain rights of which participating providers must be aware.

The right to be treated with dignity and respect

Members have the right to be treated with dignity, respect and fairness at all times. Federal law prohibits HealthSpring and its participating providers from discriminating against members (treating members unfairly) because of their race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age or national origin. If members need help with communication, such as from a language interpreter, they should be directed to call customer service. Customer service can also help members file complaints about access to facilities (such as wheelchair access). Members can also call the HHS Office for Civil Rights at **800-368-1019** or **800-537-7697** (TDD), or the Office for Civil Rights in their area for assistance.

The right to the privacy of medical records and personal health information

Federal and state law protects the privacy of member medical records and personal health information. HealthSpring and its participating providers must keep members' personal health information private as required under these laws. HealthSpring staff will make sure that unauthorized people do not see or change member records. Generally, we will get written permission from the member (or from someone to whom the member has given legal authority to make decisions on their behalf) before we give member health information to anyone who is not providing the member's medical care. There are exceptions allowed or required by law, such as releasing health information to government agencies that are checking on quality of care.

The laws that protect member privacy give members rights related to accessing information and controlling how their health information is used. HealthSpring is required to provide members with a notice that informs them of these rights and explains how we protect the privacy of their health information. For example,

members have the right to look at and obtain copies of their medical records (the provider may charge a fee for making copies), and to ask the plan's participating providers to make additions or corrections to their medical records. (If a member asks a plan's participating provider to do this, the participating provider must review the request and determine whether the changes are appropriate).

Members have the right to know how their health information has been given out and used for routine and nonroutine purposes. If they have questions or concerns about the privacy of their personal information and medical records, they should be directed to call customer service.

HealthSpring will release a member's information – including prescription drug event data – to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.

The right to see participating providers, get covered services and get prescriptions filled within a reasonable period of time

Members will get most or all of their health care from participating providers; that is, from physicians and other health providers that are part of the HealthSpring provider network. Members have the right to choose an in-network provider; HealthSpring will work with them to ensure they find physicians who accept new members.

Members have the right to go to a women's health specialist (such as a gynecologist) without a referral (applicable to HMO plans; PPO plans do not require referrals). Refer to the Prior Authorization section of this manual for additional guidance.

Members have the right to timely access to their providers and to see specialists when specialty care is needed, as well as to timely access to their prescriptions at any network pharmacy. Timely access means that members can get appointments and services within a reasonable period of time. The evidence of coverage explains how members can access participating providers to get the care and services they need, as well as their rights to receive care for medical emergencies and urgent health needs.

The right to know treatment choices and participate in decisions about their health care

Members have the right to receive full information from their providers when they receive medical care and the right to participate fully in treatment planning and decisions about their health care. Providers must explain treatment choices, planning, and health care decisions in a way that members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition, including all appropriate and medically necessary treatment options, regardless of the cost or whether they are covered by HealthSpring. This includes the right to know about the different medication management treatment programs HealthSpring offers and those in which members may participate. Members have the right to be told about any risks involved in their care, told in advance if any proposed medical care or treatment is part of a research experiment and given the choice to refuse experimental treatments.

Members have the right to receive a detailed explanation from HealthSpring if they believe that an in-network provider has denied care that they believe they are entitled to receive or should continue to receive. In these cases, members must request an initial decision as described in their plan's evidence of coverage.

Members have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if their provider advises them not to leave, and to stop taking medications. If members refuse treatment, they accept responsibility for what happens because of refusing treatment.

The right to make complaints

Members have the right to make a complaint if they have concerns or problems related to their coverage or

care. A member or an appointed or authorized representative may file grievances, concerns, appeals and coverage determinations; HealthSpring must treat them fairly and is prohibited from discriminating against them because they filed a complaint, appeal or coverage determination. To obtain information relative to this right, members should call HealthSpring customer service.

The right to obtain information about their health care coverage and cost

The evidence of coverage tells members what medical services are covered and what they have to pay. If they need more information, they should be directed to call customer service. Members have the right to an explanation from HealthSpring about any bills they receive for services not covered. We must tell members, in writing, why we will not pay for or allow them to get a service, and how they can file an appeal to ask HealthSpring to change this decision. A provider's staff should inform members about how to file an appeal, if asked, and direct members to review their evidence of coverage for more information about filing an appeal.

The right to obtain information about HealthSpring, participating providers, drug coverage and costs

Members have the right to obtain information about HealthSpring plans and operations. This includes information about our financial condition, the services we provide and participating health care providers and their qualifications. Members have the right to know how we pay participating providers, as well as obtain information about their Part D prescription coverage, including in-network pharmacies. To obtain any of this information, a provider's staff should direct members to call customer service.

The right to receive more information about members' rights

Members have the right to receive information about their rights and responsibilities. If they have questions or concerns about their rights and protections, they should be directed to call customer service. Members can also:

- Get free help and information from their State Health Insurance Assistance Program
- Obtain a free copy of the Medicare & You booklet, which contains a section about their rights and protections, by calling **800-MEDICARE (800-633-4227)** 24 hours a day, 365 days a year or by visiting [Medicare.gov](https://www.medicare.gov) > Basics > Forms, publications & mailings > [Publications](#) > Medicare & You (TTY users should call **877-486-2048**.)
- View their rights and protection online by visiting [Medicare.gov](https://www.medicare.gov) > [Basics: Your Medicare rights](#).

The right to take action if they think they have been treated unfairly or their rights are not being respected

If members think they have been treated unfairly or their rights have not been respected, there are options for what they can do. For example, members:

- Who believe they have been treated unfairly due to their race, color, national origin, disability, age or religion are encouraged to inform us immediately. They can also call the Office for Civil Rights in their area.
- Can call customer service for any other kind of concern or problem related to their rights and protections described in this section
- Can also get help from SHIP

Advance medical directives

The federal Patient Self-Determination Act grants members the right to participate in health care decision-making, including decisions about withholding resuscitative services or declining or withdrawing life-sustaining

treatment. In accordance with guidelines established by CMS, and our own policies and procedures, HealthSpring requires all participating providers to have a process in place pursuant to the intent of the Patient Self-Determination Act.

All providers contracted directly or indirectly with HealthSpring may be informed by the member that the member has executed, changed or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in their medical record.

Providers are required to document in a prominent place of a member's medical record whether the member has executed an advance directive.

If the PCP or treating provider cannot, as a matter of conscience, fulfill the member's written advance directive, they must inform the member and HealthSpring. HealthSpring and the PCP or treating provider will arrange for a transfer of care. Participating providers may not withhold the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right, under state law, of a provider to refuse to comply with an advance directive as a matter of conscience.

To ensure providers maintain the required processes for advance directives, HealthSpring conducts periodic member medical record reviews to confirm that required documentation exists.

Noncovered services

Providers may only collect fees from members for noncovered services when the member has been provided with a standardized written organization determination denial notice from HealthSpring prior to the item or service being rendered to the member, or if the member's evidence of coverage clearly states the item or service is a noncovered service.

In circumstances where there is a question whether or not the plan will cover an item or service, members or their AOR/POA have the right to request an organization determination prior to obtaining the service from the provider. If coverage is denied, HealthSpring provides the member with a standardized written organization determination denial notice that states the specific reasons for the denial and informs the member of their appeal rights. In the absence of the appropriate HealthSpring organization determination denial notice or a clear exclusion in the evidence of coverage, the member must be held harmless (i.e., cannot be held financially liable for the charges).

When a provider knows or believes that a service or item is not covered under the member's benefit, and the evidence of coverage does not explicitly state the item or service is noncovered, the provider must advise the member or AOR/POA to request a preservice organization determination from HealthSpring, or the provider can request the organization determination on the member's behalf before the provider moves forward with rendering the services, providing the item or referring the member to another provider for the noncovered item or service.

Providers may not issue any form or notice that advises the member that they will be responsible for the costs associated with noncovered services unless the member has already received the appropriate preservice organization determination denial notice from HealthSpring, or the service or item is explicitly stated as a noncovered service in the evidence of coverage. Providers cannot hold a member financially liable for services or supplies that are not explicitly stated as noncovered in the member's evidence of coverage.

Member Responsibilities

Along with certain rights, there are also responsibilities associated with being a member of HealthSpring.

Members are responsible for:

- Becoming familiar with their HealthSpring coverage and the rules they must follow to get care as a member. They can use their HealthSpring evidence of coverage and other information we provide them to learn about their coverage, what we have to pay and the rules they need to follow. They should call customer service if they have any questions or complaints.
- Knowing which providers are part of our network because, with limited exceptions, they can contact customer service for assistance in finding an in-network provider:
 - **800-668-3813** (all providers except Arizona HMO)
 - **800-627-7534** (Arizona HMO)
- Advising HealthSpring and their providers if they have other health insurance coverage
- Notifying providers when seeking care (unless it is an emergency) that they have HealthSpring Medicare Advantage plan coverage and presenting their ID card to the provider, when possible
- Giving their doctors and other providers the information needed to provide care for them and following agreed-upon treatment plans and instructions. Members are encouraged to ask questions they have of their doctors and other providers.
- Paying their plan premiums and any copayments or coinsurances they may have for the covered services they receive. They must also meet their other financial responsibilities as described in their evidence of coverage.
- Informing HealthSpring if they have any questions, concerns, problems or suggestions regarding their rights, responsibilities, coverage or HealthSpring operations
- Notifying HealthSpring customer service and their providers of any address or phone number changes as soon as possible
- Using their HealthSpring plan only to access services, medications and other benefits for themselves

DELEGATION

Delegation is a formal process by which HealthSpring enters into a written contract with an entity to provide administrative or health care services for members on the behalf of HealthSpring.

- A function may be fully or partially delegated.
 - Full delegation allows all activities of a function to be delegated
 - Partial delegation allows some of the activities to be delegated
- The decision of what functions may be considered for delegation is determined by the type of participation agreement a provider group has with HealthSpring, as well as the ability of the provider group to perform the function.
- The local HealthSpring provider representative should be contacted for detailed information about delegation.
- The authority to perform a function can be delegated by HealthSpring, but the responsibility to perform a

function cannot be delegated by HealthSpring.

- Delegated providers must comply with the responsibilities outlined in their Delegated Services Agreement and HealthSpring policies and procedures.
- Credentialing delegates must submit semiannual reports via email to the Delegation Coordinator at CredDelegation@HealthSpring.com.

ACCREDITATION

National Committee for Quality Assurance

Nondiscrimination and cultural competency

Participating providers shall provide health care services to all members consistent with the benefits covered in their benefit plan, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment or any other bases deemed unlawful under federal, state or local law.

Participating providers shall provide covered services in a culturally competent manner to all members by making a particular effort to ensure that those with limited-English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled.

Examples of how a provider can meet these requirements include, but are not limited to, translator services, interpreter services, teletypewriters and TTY connection.

HealthSpring offers interpreter services and other accommodations for the hearing-impaired. Translator services are made available for non-English speaking or limited-English proficient members. If these services are not available in their office location, providers can call Provider Customer Service at **800-230-6138** to assist with translator and TTY services.

Additional provider rights and responsibilities

Providers have rights and responsibilities in addition to those outlined in their agreement with HealthSpring.

Provider rights

You have the right to:

- Give feedback and suggestions on how service may be improved within HealthSpring
- Request to have a member removed from your care if an acceptable member-provider relationship cannot be established with a member who selected you as their PCP
- Request claims reconsiderations for any claims you believe were not paid according to payment policy
- Request an appeal for any claims you believe were not paid in alignment with the level of care rendered or clinical practice guidelines
- Request to discuss any referral or prior authorization request with the medical director or chief medical officer at various times in the review process

Provider responsibilities

PCPs are responsible for:

- Using best efforts to provide care to new members within four months of their enrollment with HealthSpring
- Using best efforts to provide follow-up care to members who have been in the hospital setting, within 10 days of hospital discharge
- Coordinating routine preventive care for members with HMO plan coverage, along with any ancillary services that need to be rendered with prior authorization

Specialists are responsible for:

- Coordinating the referral process (including obtaining prior authorizations) for further care they recommend for members with HMO plan coverage. This responsibility **does not revert to the PCP** while the care of the member is under the direction of the specialist.
- Providing continuous access to care for HealthSpring members 24 hours a day, 365 days a year

All providers are responsible for:

- Treating HealthSpring members the same as all other members in their practice, regardless of the type or amount of reimbursement
- Providing continuous access to care for HealthSpring members 24 hours a day, 365 days a year
- Coding to the highest level of specificity necessary to accurately and fully describe a member's acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.
- Arranging for another provider to render services on their behalf in the event they are temporarily unavailable or unable to provide member care or referral services for a HealthSpring member. This coverage cannot be provided by an emergency room.
- Providing continuity of care upon network termination in accordance with their contract
- Utilizing HealthSpring participating providers and facilities, for members with HMO plan coverage, when their services are available and can meet members' needs. Approval prior to making referrals outside of the HealthSpring provider network may be required.
- Participating in HealthSpring peer-review activities as they relate to the quality management and utilization review programs
- Cooperating with HealthSpring quality improvement activities to improve the quality of care and services, as well as members' experience. This includes the submission of data requested by HealthSpring and participation in HealthSpring QI programs.
- Allowing HealthSpring to use their performance data, including the collection, evaluation and use of data for QI activities
- Maintaining member information and records in a confidential and secure manner
- Freely and openly discussing with members all available treatment options, regardless of whether the services may be covered services under the member's benefit plan, including medication treatment options, regardless of benefit limitations
- Not balance billing for rendering HealthSpring-covered services. This excludes the collection of standard

copayments. You may bill a member for a procedure that is not a covered benefit if you have followed the appropriate procedures outlined in the [Member Eligibility Verification](#) section.

- Submitting all claims within the time frame specified in your contract

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is developed and maintained by NCQA, an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims and encounters), supplemental data (EHR and vendor data) and medical record review data. HEDIS includes measures such as comprehensive diabetes care, adult access to ambulatory and preventive care, controlling high blood pressure, breast cancer screening, medication reconciliation post discharge and colorectal cancer screening.

Plan-wide HEDIS measures are reported annually in June for the prior year and represent a mandated activity for health plans contracted with CMS. A portion of measures are designated as “hybrid,” and plans are allowed to collect medical record data for the prior measure year during its annual medical record review. The record collections process typically runs from the end of January until the first week in May. Each spring, HealthSpring representatives collect records from provider offices as part of this process and to establish final HEDIS scores.

Selected provider offices will be contacted and requested to assist in these medical record collections.

All records are handled in accordance with HealthSpring privacy policies and in compliance with the HIPAA privacy rules. Only the minimum necessary amount of information is requested, and it is used solely for the purpose of the HEDIS initiative. HEDIS records collection is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 C.F.R. §§ 164.501 and 506].

HealthSpring HEDIS results are available upon request by emailing the HealthSpring Medicare Advantage QI department at FAX-SOL@HealthSpring.com.

QUALITY MANAGEMENT

HealthSpring continually monitors its QI program and makes changes, as needed, to its structure, content, methods, and staffing. Changes to the program are accompanied by policy and procedure revisions, as well as staff training, as required. The program operates under the umbrella of the Corporate Quality Improvement Committee, which reports to the HealthSpring Quality Management governing body and is reviewed and updated annually in collaboration with the QI department. The HealthSpring National Physician Advisory Committee, which is made up of network providers, also reviews the program and its clinical practice guidelines at certain intervals and offers improvement recommendations.

Quality Improvement Program

CMS requires Medicare Advantage organizations to have an ongoing QI program to ensure health plans have the necessary infrastructure to coordinate care, and to promote quality, performance and efficiency on an ongoing basis. The requirements for the QI program are based on regulation at 42 C.F.R. § 422.152.

The HealthSpring Medicare Advantage QI program is dedicated to improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services.

Corporate Quality Improvement Committee

This committee has oversight authority for QI activities across the organization and is responsible for ensuring the development and implementation of HealthSpring QI program initiatives, annual QI and utilization management

updates, and care management work plans, as well as reviewing and approving health service policies, monitoring credentialing, providing delegation oversight and member appeal activity, and reviewing clinical and service quality initiatives.

To monitor and facilitate implementation of the QI program, the committee has established appropriate sub-committees that provide oversight of the functions and activities within the scope of the organization's QI program. The committee may also appoint and convene ad-hoc work groups as indicated.

Values

- Integrity – We always conduct ourselves in a professional and ethical manner.
- Respect – We all have value and will treat others with dignity and respect.
- Team – We recognize that employees are our main asset and encourage their development.
- Communications – We encourage the free exchange of thoughts and ideas.
- Balance – We manage both our personal and company priorities.
- Excellence – We continuously strive to exceed our members' expectations.
- Prudence – We always use the company's financial resources wisely.

Quality principles

HealthSpring shall apply the guiding values described above to its oversight and operation of its products and internal systems, and:

- Provide services that are clinically driven, cost effective and outcome oriented
- Provide services that are culturally informed, sensitive and responsive
- Provide services that enable members to live in the least restrictive, most integrated community setting appropriate to meet their health care needs
- Ensure that guidelines and criteria are based on professional standards and evidence-based practices that are adapted to account for regional, rural, and urban differences
- Foster an environment of quality of care and service within HealthSpring Medicare Advantage and through our provider partners
- Promote member safety as an overriding consideration in decision making

Goals:

The primary objective of the QI program is to promote and build quality into the organizational structure and processes to meet our mission of improving the health of the communities we serve by delivering quality and cost-effective health care benefits and services. The goals we have established to meet this objective include:

- Fostering communication across the enterprise
- Collaboratively working toward the achievement of established goals

- Monitoring progress of improvement efforts to meet established goals
- Providing the necessary oversight and leadership reporting
- Ensuring member care and service are provided according to established goals and metrics
- Ensuring the identification and analysis of opportunities for improvement, with implementation of actions and follow up as needed
- Promoting consistency in QI program activities
- Ensuring the QI program is sufficiently separate from fiscal and administrative management to prevent any undue influence decision-making regarding organizational determinations and/or appeals of adverse determinations of covered benefits
- Assuring timely access to and availability of safe and appropriate physical and behavioral health services for the population served by HealthSpring
- Ensuring services are provided by qualified individuals and organizations, including those with the qualifications and experience appropriate to service members with special needs
- Promoting the use of evidence-based practices and care guidelines
- Improving the ability of all HealthSpring Medicare Advantage staff to apply quality methodology through a program of education, training and mentoring
- Maintaining a rigorous delegation oversight process
- Ensuring program relevancy through an understanding of member demographics and epidemiological data, and providing services and interventions that address the diverse cultural, ethnic, racial, linguistic and other unique needs of members
- Maintaining a clinical risk management and patient safety program that includes the documentation of quality of care, adverse and never events, critical incidents, and safety issues as described in the quality of care and clinical risk management patient safety component of this QI program
- Ensuring adequate infrastructure and resources to support the QI program
- Ensuring provider involvement in maintaining and improving the health of HealthSpring Medicare Advantage members through a comprehensive provider partnership
- Maintaining and monitoring a MOC designed for HealthSpring Medicare Advantage SNP members
- Promoting population health management strategies and activities to ensure holistic care for members

The Quality Improvement program provides guidance for the management and coordination of all quality improvement and quality management activities throughout the HealthSpring Medicare Advantage organization, its affiliates and delegated entities. It continuously monitors, evaluates and strives to improve the clinical care and services provided to HealthSpring members relating to both their physical and behavioral health. The program also defines the health plan's methodology for identifying improvement opportunities as well as for developing and implementing initiatives to impact the identified opportunities.

SPECIAL NEEDS PLANS

The CMS regulation Medicare Improvements for Patients and Providers Act of 2008 mandates that all special needs plans (SNPs) have a filed and approved model of care (MOC) by Jan. 1, 2010. The Patient Protection and Affordable Care Act reinforced the importance of the SNP MOC as a fundamental component by requiring NCQA review and approval.

SNP Eligibility Criteria

SNPs are designed for specific groups of members with special health care needs. Only members who meet the CMS criteria for the SNP types listed below may enroll in a SNP plan.

- Dual Eligible Special Needs Plan (D-SNP): For members who are eligible for Medicaid and Medicare
- Chronic Condition Special Needs Plan (C-SNP): For members with chronic conditions
- Institutional Special Needs Plan (I-SNP): For members who reside in a long-term care facility

CMS mandates that each of these SNP types have a MOC. The MOC is an evidenced-based care management program that facilitates early and ongoing assessments and identifies health risks and major changes in the health status of SNP members. It provides structure and describes the coordination of care, benefits and services targeted to improve the overall health of our SNP members. The MOC also serves to ensure that the unique needs of our SNP members are identified and appropriately addressed.

The SNP MOC identifies four key care management components:

SNP population – The unique characteristics of the overall most vulnerable SNP members

Care coordination – The SNP staff structure, health risk assessment, face-to-face encounter, individualized care plan, interdisciplinary care team and care-transition process, which are used to identify the services and benefits offered through the plan and are available to our SNP members. The wide range of services is targeted to help SNP members achieve their optimal health and improve their connection to care.

Provider network – Providers with specialized expertise correspond to the target population in our SNP program, collaborate with the interdisciplinary care team and contribute to a member's individualized care plan. Participating providers use evidence-based medicine, when appropriate, and care-transition protocols.

MOC quality measurement and performance improvement – This section of the MOC includes clinical and member satisfaction goals, as well as the ongoing performance evaluation of the SNP MOC.

SNP MOC Training

CMS mandates the completion of initial and annual SNP MOC training for staff and providers, as well as documentation to reflect that training was completed.

SNP MOC Process

The HealthSpring SNP MOC care management process focuses on the unique needs of SNP members. The goal is to identify the need for interventions, care coordination and care transitions, as well as identify barriers to care and to provide education, early detection and symptom management.

The MOC includes key program components, which are benefits and services provided to ensure appropriate care coordination and care management, such as:

- **Health risk assessment.** To identify care needs, HealthSpring conducts health risk assessments of SNP members within 90 days of their enrollment, and then annually within 365 days of their last health risk assessment.
- **Face-to-face encounter.** A face-to-face encounter must occur, as feasible and with the SNP member's consent, at least annually beginning within the first 12 months of enrollment. The encounter must be

between the SNP member and a member of their interdisciplinary care team, as well as HealthSpring case management and coordination staff or participating health care providers. The encounter must either be in person or through a visual, real-time interactive telehealth visit.

- **Individualized Care Plan.** Health risk assessment results and evidence-based clinical protocols are utilized to develop an individualized care plan. The HealthSpring Care Management team is responsible for its development. ICP is a personalized, written plan for a member's care that contains the member's healthcare preferences, self-management goals and description of services specifically tailored to the member's needs.
- **Interdisciplinary Care Team.** This team comprises the SNP member, care managers, the PCP and other providers or support personnel involved in the member's care. They assist in coordinating care and services, which includes reviewing the individualized care plan. Other providers may be included on the team from various disciplines and specialties, including community resource providers, based on the member's individual needs.
- **Care transition.** A change in health status could result in new care management needs. As a result, our care management teams provide support to address the specific needs of SNP members.
 - CMS requires health plans to maintain a clear and comprehensive MOC that details how the plan will ensure high-quality care for members enrolled in their SNPs. Within the MOC, health plans must detail how they communicate and coordinate care with providers, including acute care hospitals.
 - HealthSpring is committed to supporting care transitions for all members. This is especially true for our most vulnerable members who are enrolled in SNPs because they are dually eligible for both Medicaid and Medicare, or they are managing chronic conditions.
 - As described in the HealthSpring MOC, the plan works to support quality care and prevent fragmentation in the care transition process. This is achieved through strong member and provider engagement, transparent information-sharing to support continuity of care, and the provision of tools and support that promote knowledge and self-management of a member's health conditions.
 - By sharing the individualized care plans with acute care hospitals, HealthSpring ensures that providers and members are aware and aligned on a member's health history and ongoing care goals. This document also provides a single point of contact for both the provider and the member, should any care coordination needs be identified during hospitalization.

As a provider, your participation is required for the coordination of care, care plan management and identification of additional health care needs for SNP members.

HealthSpring utilizes risk-stratification methodologies to identify the most vulnerable SNP members, such as those who are frail or disabled, have multiple chronic illnesses or are at the end of life. The risk-stratification process includes input from the provider, member and data analysis.

SNP Interdisciplinary Care Team

HealthSpring will invite you to participate in an interdisciplinary care team meeting when you have a patient who is a SNP member requiring care management. We encourage you to participate in the meeting, and to collaborate in the care planning and identification of care planning goals for the SNP member.

The HealthSpring SNP MOC is geared toward supporting members and their providers with timely and continued communication during transitions of care, such as from a hospital to a skilled nursing facility or home, whether planned or unplanned. A HealthSpring care manager ensures that care is coordinated across the inpatient and post-acute settings, and that a safe and appropriate discharge plan is executed. This includes communicating with the member, the caregiver, the facility and the PCP. A PCP's involvement as a part of their patient's interdisciplinary care team is a critical aspect of the transition-of-care protocols.

If a provider wants to discuss or request a copy of a SNP member's care plan or refer a SNP member to or participate in an interdisciplinary care team meeting, they should call Population Health Operations intake at **866-382-0518**.

SNP health risk assessment contact information

When a SNP member completes a health risk assessment, it can be utilized to develop a care plan with the member. A copy can be obtained by calling our Health Risk Assessment department at **800-331-6769**. The member and their assigned PCP will receive a copy of the member's care plan based on the health risk assessment responses.

SNP scope

The SNP encompasses:

- All aspects of physical and behavioral care, including accessibility, availability, level of care, continuity, appropriateness, timeliness and clinical effectiveness of care and services provided through HealthSpring and its contracted providers and organizations
- All aspects of provider performance relating to access to care and quality of care, including provider credentialing, confidentiality, medical record keeping and fiscal and billing activities
- All covered services, including assuring services are rendered in a culturally and linguistically appropriate manner
- All professional and institutional care in all settings including hospitals, skilled nursing facilities, outpatient facilities and at home
- All providers and any delegated or subcontracted providers
- Management of behavioral health care and substance use disorder care and services
- Aspects of HealthSpring internal administrative processes that are related to service and quality of care, including credentialing, QI, pharmacy, health education, health risk assessments, clinical practice guidelines, utilization management, member safety, case management, disease management, special needs, complaints, grievances and appeals, member service, provider network, provider education, medical records, member outreach, claims payment and information systems
- All SNP MOC activities
- Medicare Advantage members

COMPLIANCE AND ETHICS

HealthSpring Corporate Compliance Program

The purpose of the HealthSpring corporate compliance program is to articulate the commitment of HealthSpring to compliance. It also serves to encourage our employees, contractors and other interested parties to develop a better understanding of the laws and regulations that govern HealthSpring operations. The HealthSpring corporate compliance program ensures that all practices and programs are conducted in compliance with those applicable

laws and regulations.

HealthSpring and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Noncompliance with regulatory standards undermines the business reputation and credibility of HealthSpring with federal and state governments, subcontractors, pharmacies, providers and, most important, its members. HealthSpring and its employees are also committed to meeting all contractual obligations set forth in HealthSpring contracts with CMS. These contracts allow HealthSpring to offer Medicare Advantage and Medicare Part D products and services to Medicare members.

The corporate compliance program is designed to prevent violations of federal and state laws governing the HealthSpring lines of business including, but not limited to, health care fraud and abuse laws. In the event such violations occur, the corporate compliance program will promote early and accurate detection, prompt resolution and, when necessary, disclosure to the appropriate governmental authorities. HealthSpring has in place policies and procedures for coordinating and cooperating with Medicare Drug Integrity Contractors, CMS, state regulatory agencies, congressional offices and law enforcement. HealthSpring also has policies that delineate that HealthSpring will cooperate with any audits conducted by CMS, Medicare Drug Integrity Contractors or law enforcement or their designees.

To report suspected or detected Medicare Advantage plan noncompliance, contact:

HealthSpring
Attn: Compliance Department
PO Box 20002
Nashville, TN 37202

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor or other party that reports compliance concerns in good faith can do so without fear of retaliation.

You may request a copy of the HealthSpring compliance program document by contacting Provider Relations.

Fraud, Waste and Abuse

HealthSpring goes to great lengths to ensure that our providers are reputable and are able to provide quality care. However, there is always a possibility that a provider or a consumer will engage in unethical, potentially fraudulent practices. Even a single fraudulent claim can raise the cost of health care benefits for everyone.

What is health care fraud?

Health care fraud is a crime. Health care fraud means to deceive another, like a private insurer, by intentionally misrepresenting or concealing a material fact or facts in order to obtain money or property, such as health care coverage or benefits. Fraud takes many forms and can include direct misrepresentations as well as half-truths and the knowing concealment of facts. Some examples of provider health care fraud are:

- Billing for services not actually performed or for drugs not actually dispensed
- Falsifying a diagnosis to justify tests, surgeries or other procedures that aren't medically necessary
- Billing for a higher quantity of drugs than was actually dispensed
- Misrepresenting procedures performed to obtain payment for noncovered services, such as cosmetic surgery
- Upcoding – billing for a more costly service than the one actually performed
- Unbundling – billing each stage of a procedure as if it were a separate procedure
- Accepting kickbacks for referral

The Special Investigations Department is responsible for minimizing the HealthSpring risk of health care fraud. This unit partners with HealthSpring key internal matrix partners and others to help identify suspicious claims, stop payments to fraudulent providers and punish wrongdoers.

The SID also works with state and federal law enforcement, regulatory agencies and other insurance companies to detect and prevent health care fraud and assist in the pursuit of restitution and/or prosecution of health care fraud offenders.

To report potential fraud, waste and abuse, please contact the HealthSpring Special Investigations Department:

Mail

Health Care Service Corporation
Special Investigations Department
300 E. Randolph Street, 35th Floor
Chicago, Illinois 60601

Phone: 855-249-6524

Claims data

As part of an ongoing effort to improve the delivery and affordability of health care to our members, HealthSpring conducts periodic analyses of all levels of CPT, ICD-10 and HCPCS codes billed by participating providers. These analyses allow us to comply with regulatory requirements for the prevention of fraud, waste and abuse, and to supply participating providers with useful information to meet their own compliance needs in this area.

HealthSpring will review providers' coding and may review medical records of those who continue to show significant variance from their peers. We strive to ensure compliance and enhance the quality of claims data, benefitting our medical management efforts and the provider community. As a result, you may be contacted by HealthSpring contracted partners to provide medical records to conduct reviews to substantiate coding and billing.

Steps to meet your fraud, waste and abuse obligations

Review and revise your coding policies and procedures for compliance and adherence to CMS guidelines to ensure they are consistent with official coding standards.

To access education resources about how to avoid common coverage, coding and billing errors, go to [CMS.gov](https://www.cms.gov) > Training & Education > Medicare Learning Network (MLN): Resources & training > [Provider Compliance](#).

Web-based training course:

- Combating Medicare Parts C and D Fraud, Waste and Abuse
- Medicare Fraud & Abuse: Prevent, Detect, Report

HealthSpring Medicare Advantage Program Requirements

The terms and conditions herein are included to meet federal statutory and regulatory requirements of the federal Medicare Advantage program under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program"). Provider understands that the specific terms as set forth herein are subject to modification in accordance with federal statutory and regulatory changes to the Medicare Advantage program. Such modification shall not require the consent of provider or HealthSpring and will be effective immediately on the effective date thereof.

Books and Records: Governmental and Internal Audits and Inspections

Provider shall permit the HHS, the Comptroller General or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to provider's performance of the Agreement and transactions related to the CMS Contract (collectively, "records"). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit provider's records for any particular contract period under the CMS Contract shall exist for a period of 10 years from the later of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the "Audit Period"). The provider shall keep and maintain accurate and complete records throughout the term of the Agreement and the Audit Period.

Unless agreed upon otherwise by HealthSpring, the provider shall have 60 days to produce requested records. Failure to produce records within the required time frame may result in services being deemed unsupported and other adverse findings, and corresponding repayment demands. In the event that an inspection, evaluation or audit of records leads to adverse findings, HealthSpring shall have the right to deny future claims submitted by the provider. In such a case, the provider shall have the right to appeal any such denial on a claim-by-claim basis.

For internal audits, HealthSpring requires:

- Providers to produce records at HealthSpring or designee request within 60 days
- Remediation steps from audit determinations to include, but not limited to, training, recoupment and data clean-up
- That when providers fail to comply with records requests, their claims may be deemed unsupported, and we can bring breach of contract against the claims
- The option to recoup from providers for retractions

Privacy and Confidentiality Safeguards

Provider shall safeguard the privacy and confidentiality of members and shall ensure the accuracy of the health records of members. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information, and/or medical records (including prescription records) of members including, but not limited, to the Standards for Privacy of Individually Identifiable Information promulgated pursuant to HIPAA.


Patient Hold Harmless

Participating providers are prohibited from balance billing HealthSpring members including, but not limited to, situations involving nonpayment by HealthSpring, insolvency of HealthSpring or HealthSpring breach of its agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against members or persons, other than HealthSpring, acting on behalf of members for covered services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances or deductibles for covered services in accordance with the terms of the applicable member's benefit plan, or for collecting payment when rendering noncovered services if the provider complies with the requirements of the **Noncovered services** section of this manual.


APPENDIX

2026 Member ID Cards


PPO: HealthSpring Medicare Advantage

		<Plan Name> <Plan Type>	
<Contract/PBP[/segment]>			
Name	<Customer Full Name>		
ID	<Customer ID>		
Health Plan	<(80840)>		
Effective Date	<Effective Date>		
[Dental Plan	<Dental Benefit>]		
		Part B Drugs	
		[RxBIN <XXXXXXXX>]	
		[RxPCN <XXXXXXXX>]	
		[RxGRP <XXXXXXXX>]	
[No PCP Required]		COPAYS (IN/OON)	
[No Referral Required]			
PCP	<\$xx/\$xx or xx%>	Specialist	<\$xx/\$xx or xx%>
Emergency	<\$xx>	Urgent care	<\$xx>


HMO: HealthSpring Medicare Advantage*

		<Plan Name> <Plan Type>	
<Contract/PBP[/segment]>			
Name	<Customer Full Name>		
ID	<Customer ID>		
Health Plan	<(80840)>		
Effective Date	<Effective Date>		
[Dental Plan	<Dental Benefit>]		
		Part B Drugs	
		[RxBIN <XXXXXXXX>]	
		[RxPCN <XXXXXXXX>]	
		[RxGRP <XXXXXXXX>]	
[No Referral Required]		COPAYS	
PCP	<\$xx>	Specialist	<\$xx>
Emergency	<\$xx>	Urgent care	<\$xx>

PPO: HealthSpring Medicare Advantage Prescription Drug

		<Plan Name> <Plan Type>	
<Contract/PBP[/segment]>			
Name	<Customer Full Name>		
ID	<Customer ID>		
Health Plan	<(80840)>		
Effective Date	<Effective Date>		
[Dental Plan	<Dental Benefit>]		
		MedicareRx Prescription Drug Coverage	
		[RxBIN <XXXXXXXX>]	
		[RxPCN <XXXXXXXX>]	
		[RxGRP <XXXXXXXX>]	
[No PCP Required]		COPAYS	
[No Referral Required]			
PCP	<\$xx/\$xx or xx%>	Specialist	<\$xx/\$xx or xx%>
Emergency	<\$xx>	Urgent care	<\$xx>

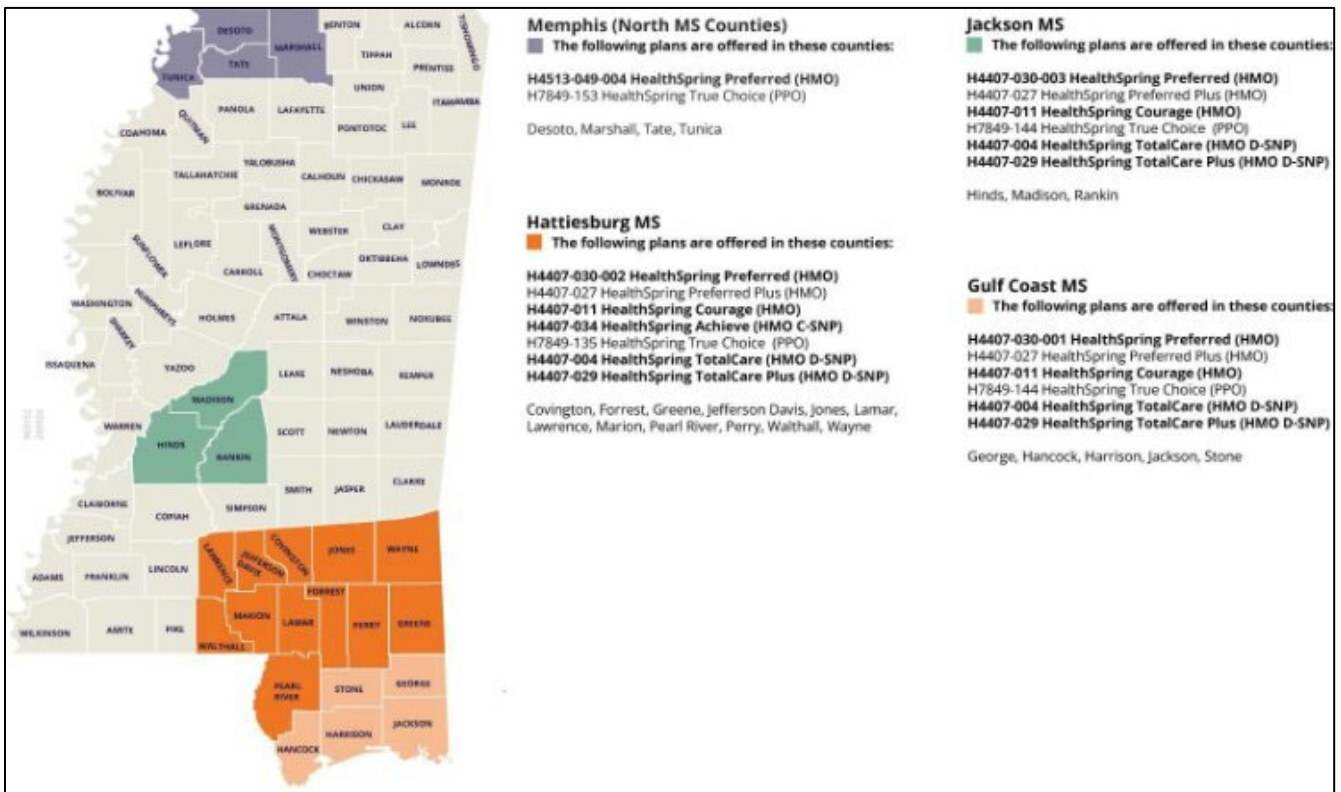
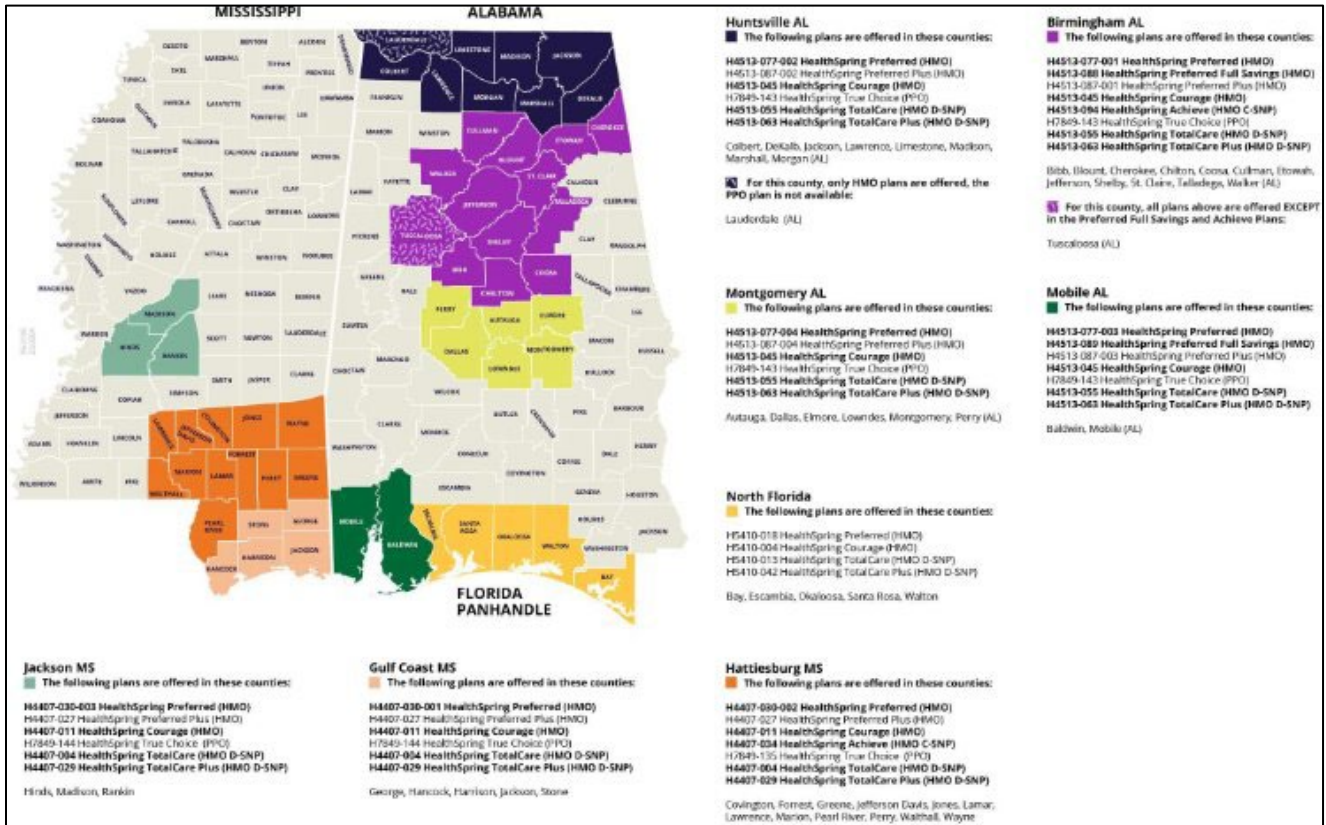
HMO: HealthSpring Medicare Advantage Prescription Drug*

		<Plan Name> <Plan Type>	
<Contract/PBP[/segment]>			
Name	<Customer Full Name>		
ID	<Customer ID>		
Health Plan	<(80840)>		
Effective Date	<Effective Date>		
[Dental Plan	<Dental Benefit>]		
		MedicareRx Prescription Drug Coverage	
		[RxBIN <XXXXXXXX>]	
		[RxPCN <XXXXXXXX>]	
		[RxGRP <XXXXXXXX>]	
[No Referral Required]		COPAYS	
PCP	<\$xx>	Specialist	<\$xx>
Emergency	<\$xx>	Urgent care	<\$xx>

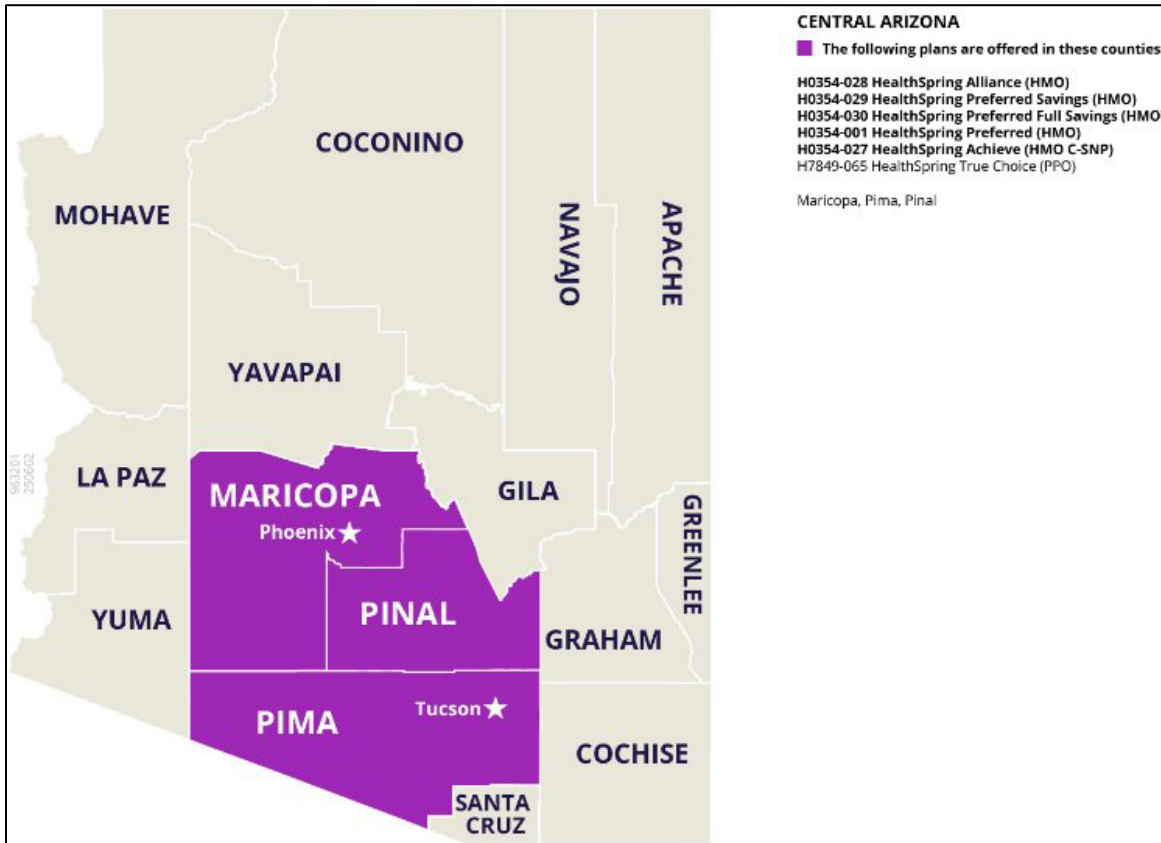
* This sample ID card is for members with an HMO plan that does not require referrals. IDs card for members with an HMO plan that requires referrals will not show "[No Referral Required]."

SERVICE AREA MAPS

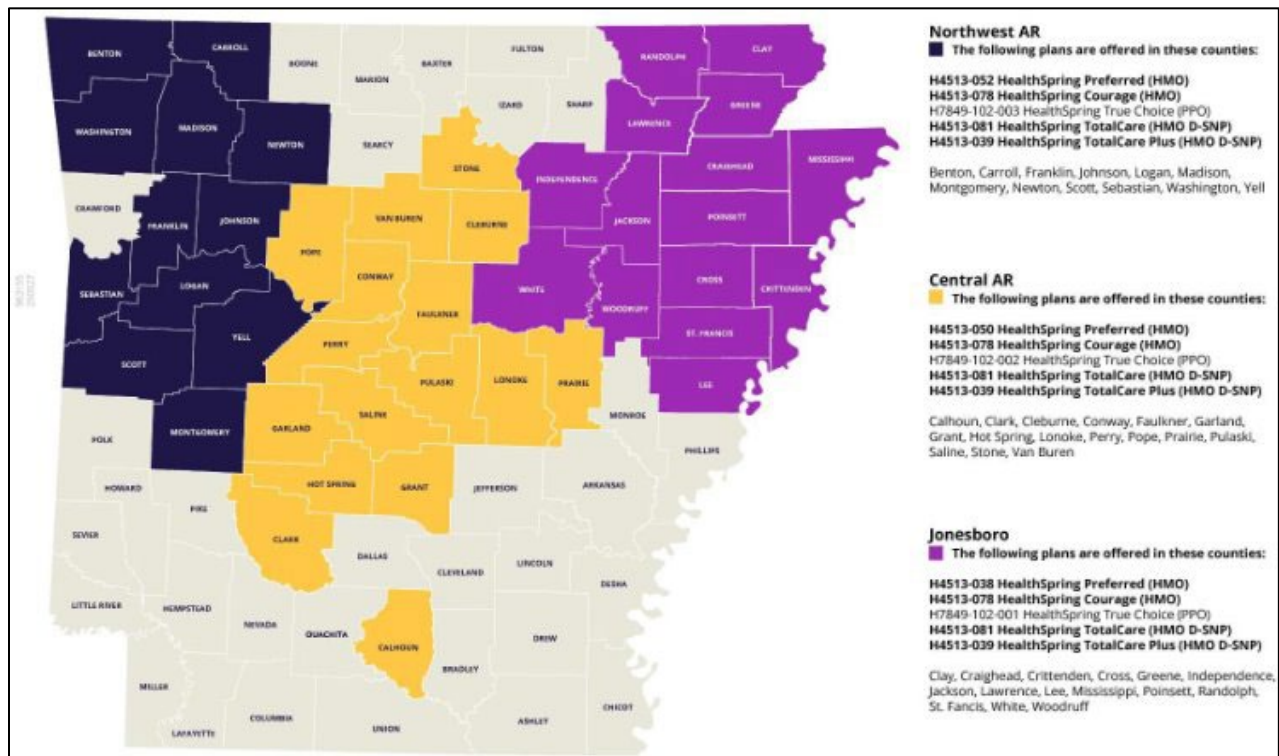
Alabama, North Florida and North and South Mississippi



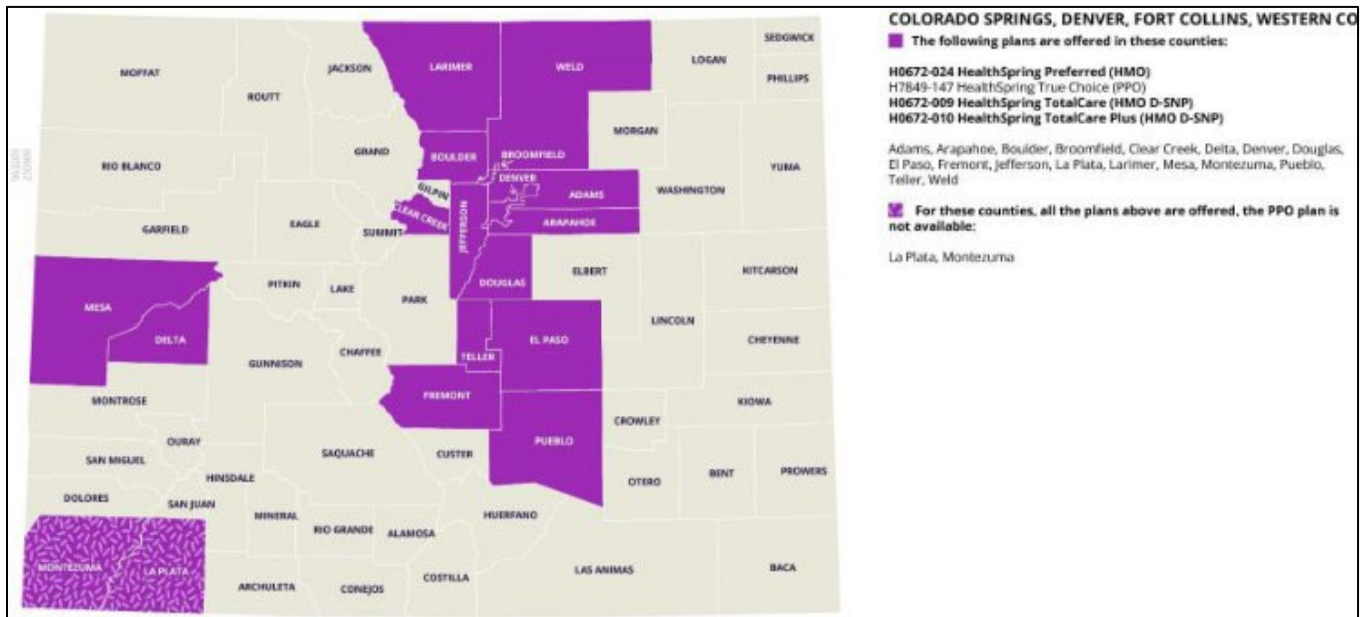
Arizona



Arkansas



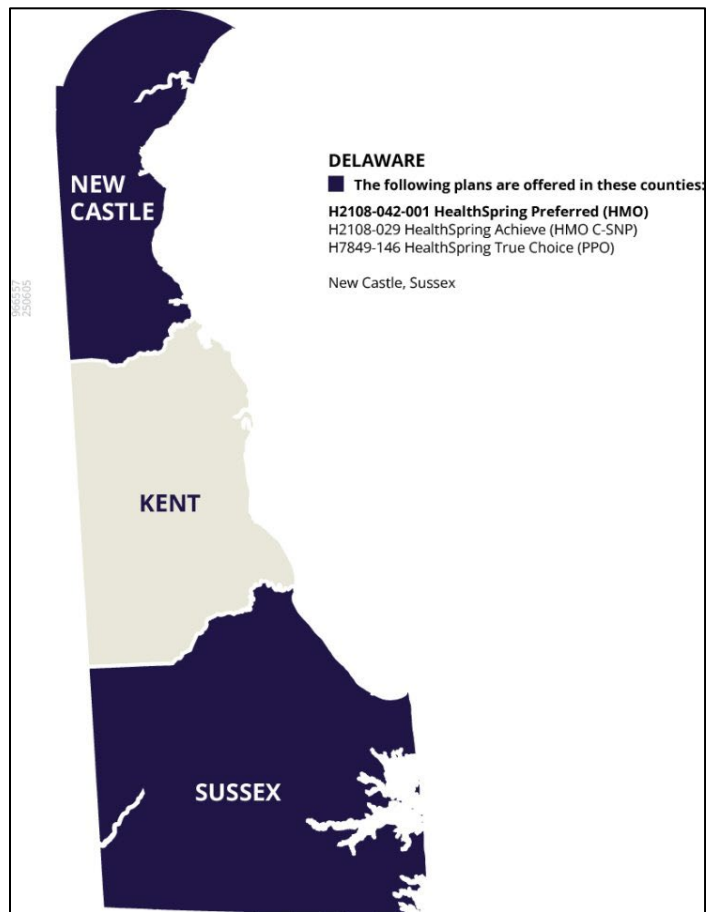
Colorado



Connecticut



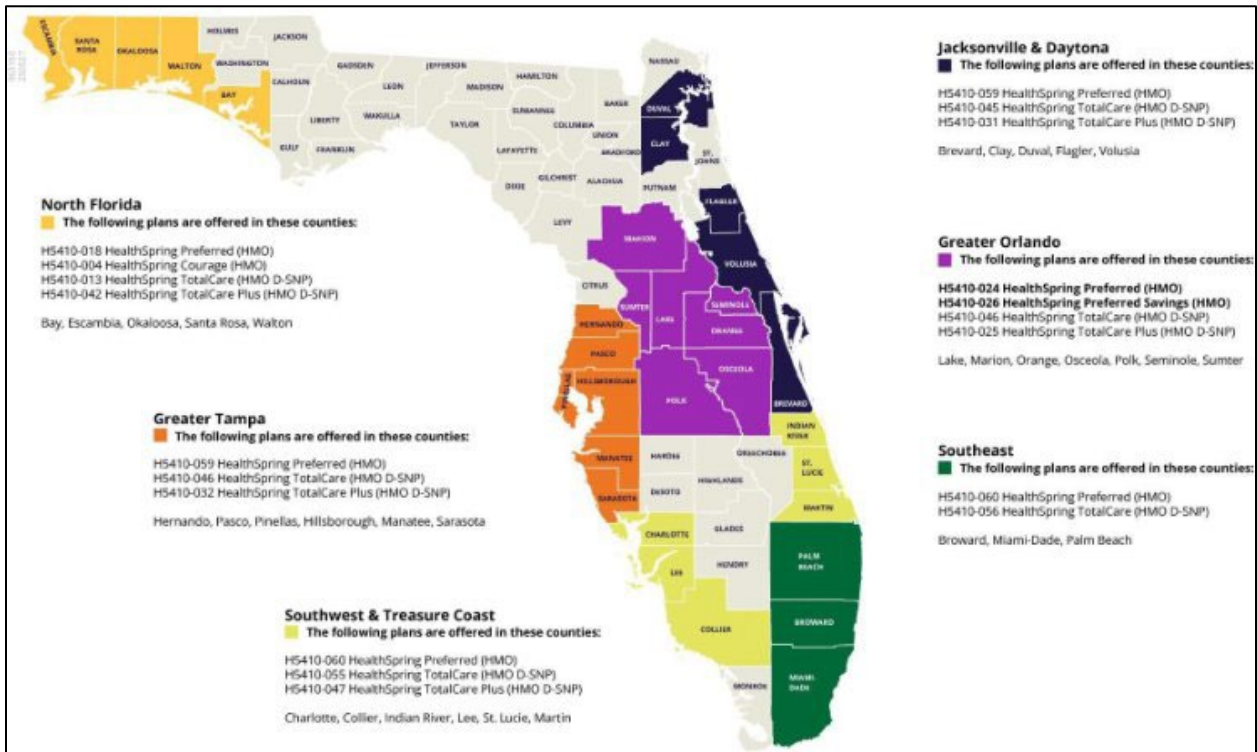
Delaware



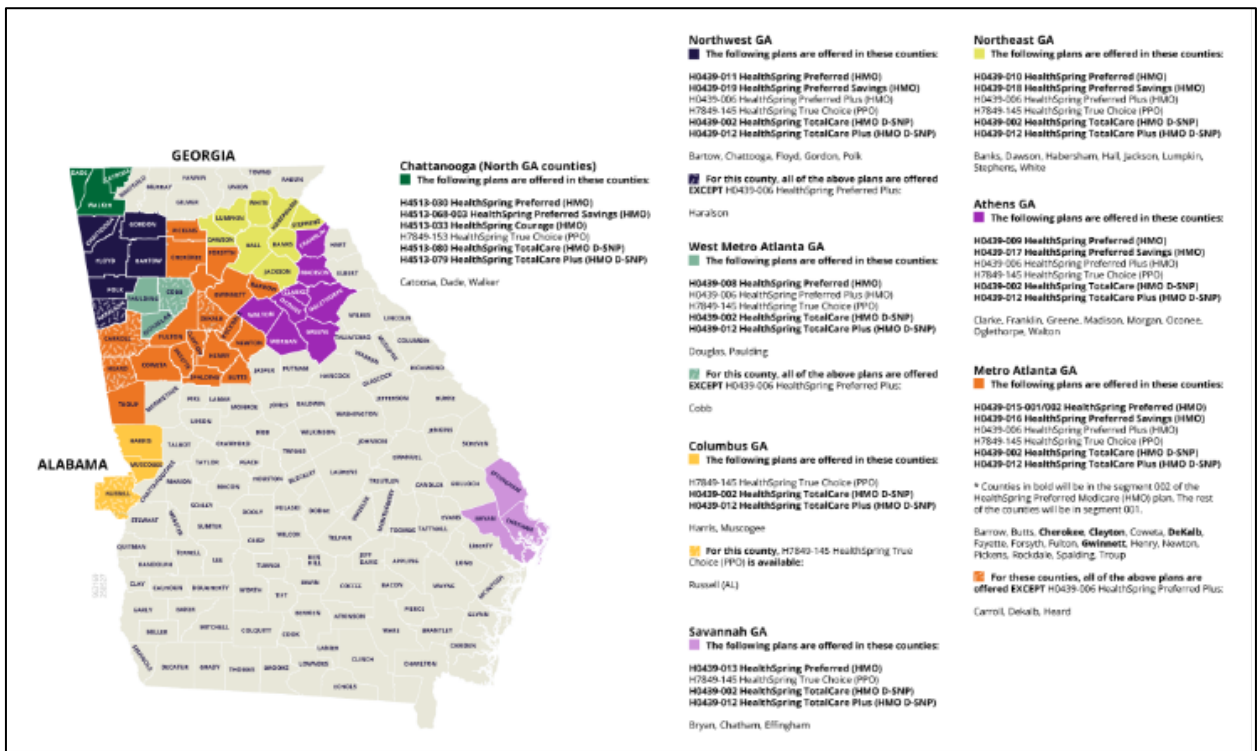
District of Columbia



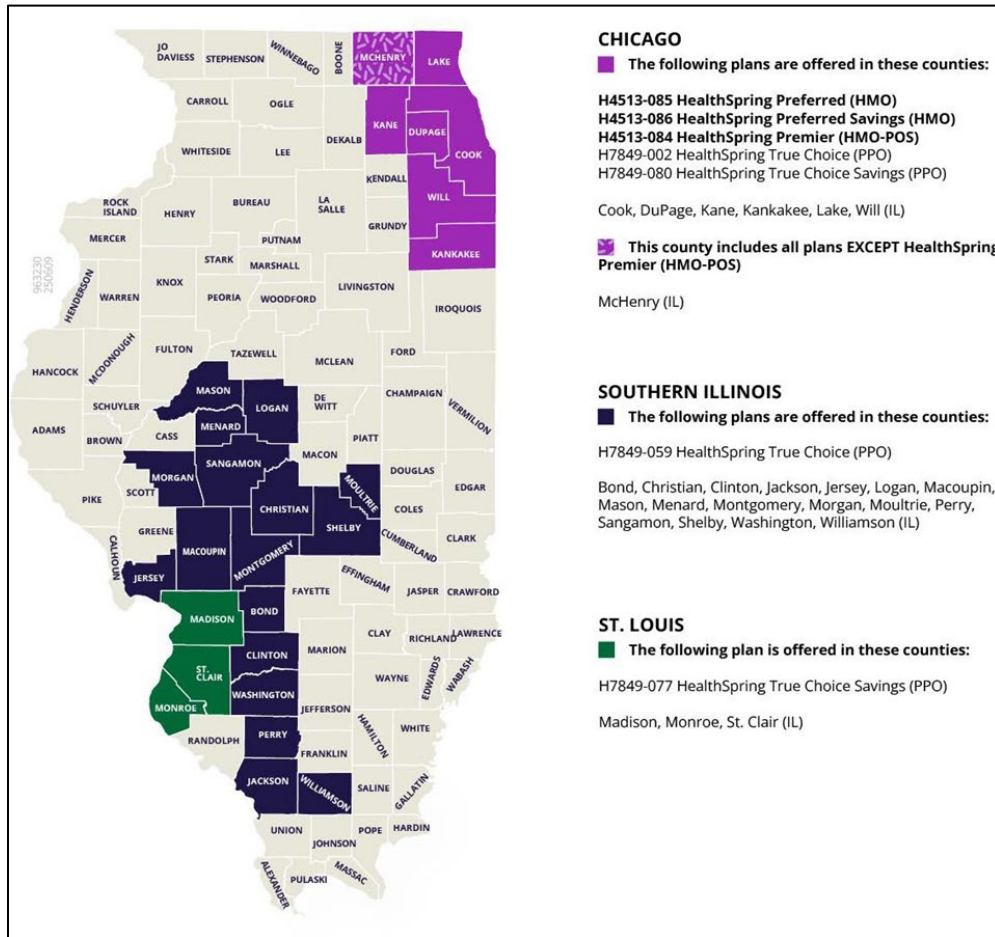
Florida



Georgia



Illinois



CHICAGO

The following plans are offered in these counties:

- H4513-085 HealthSpring Preferred (HMO)
- H4513-086 HealthSpring Preferred Savings (HMO)
- H4513-084 HealthSpring Premier (HMO-POS)
- H7849-002 HealthSpring True Choice (PPO)
- H7849-080 HealthSpring True Choice Savings (PPO)

Cook, DuPage, Kane, Kankakee, Lake, Will (IL)

This county includes all plans EXCEPT HealthSpring Premier (HMO-POS)

McHenry (IL)

SOUTHERN ILLINOIS

The following plans are offered in these counties:

- H7849-059 HealthSpring True Choice (PPO)

Bond, Christian, Clinton, Jackson, Jersey, Logan, Macoupin, Mason, Menard, Montgomery, Morgan, Moultrie, Perry, Sangamon, Shelby, Washington, Williamson (IL)

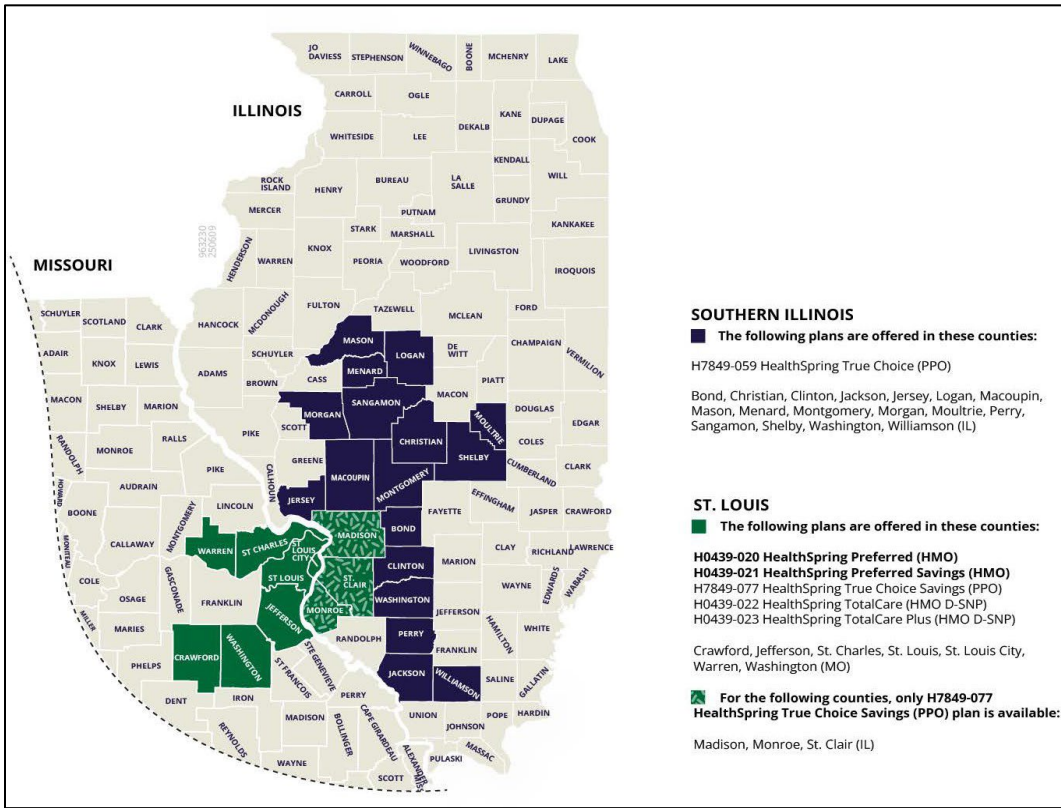
ST. LOUIS

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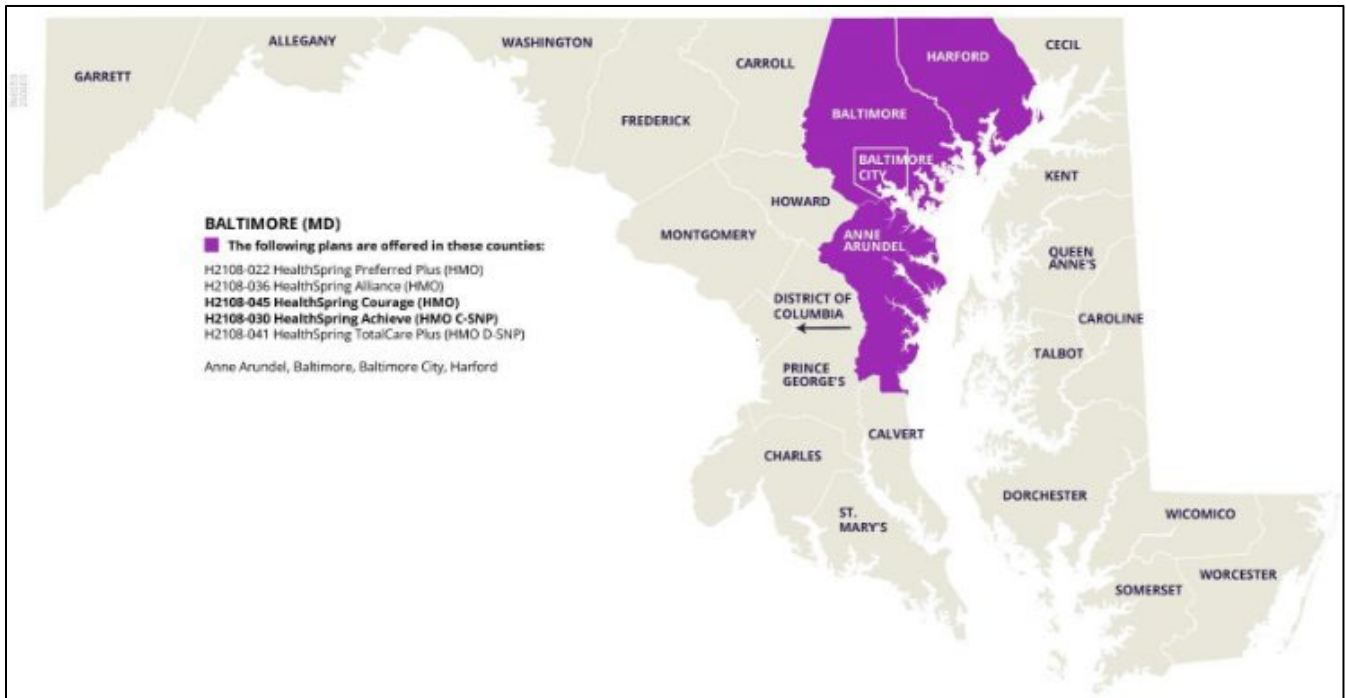
- H7849-077 HealthSpring True Choice Savings (PPO)

Madison, Monroe, St. Clair (IL)

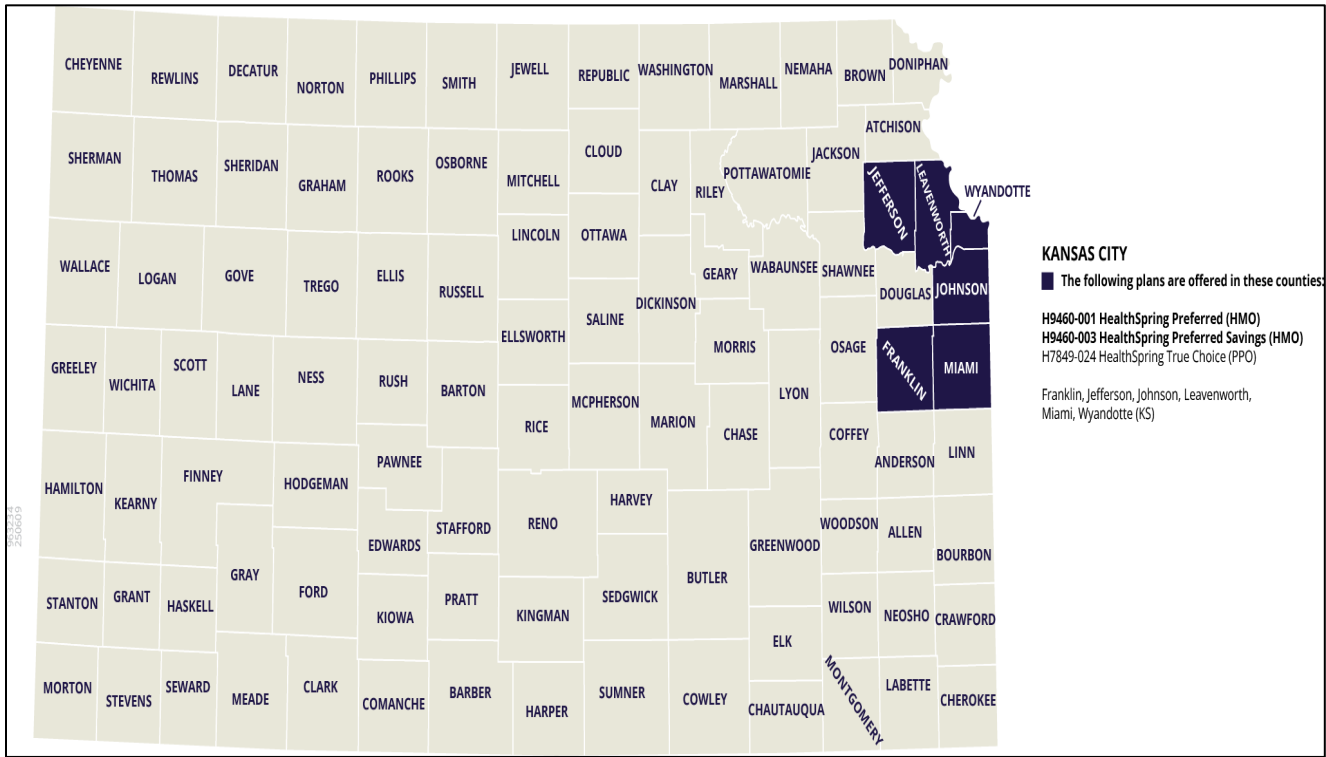
Southern Illinois and St. Louis



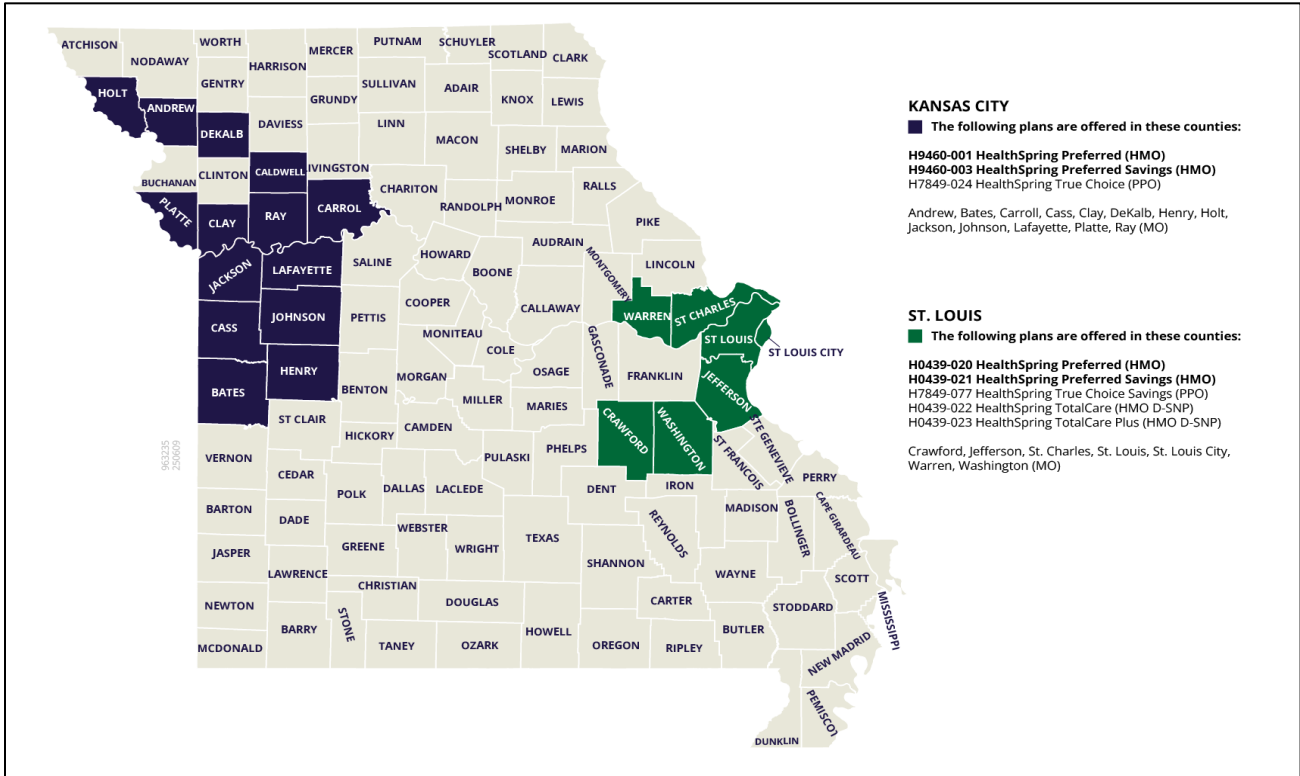
Maryland



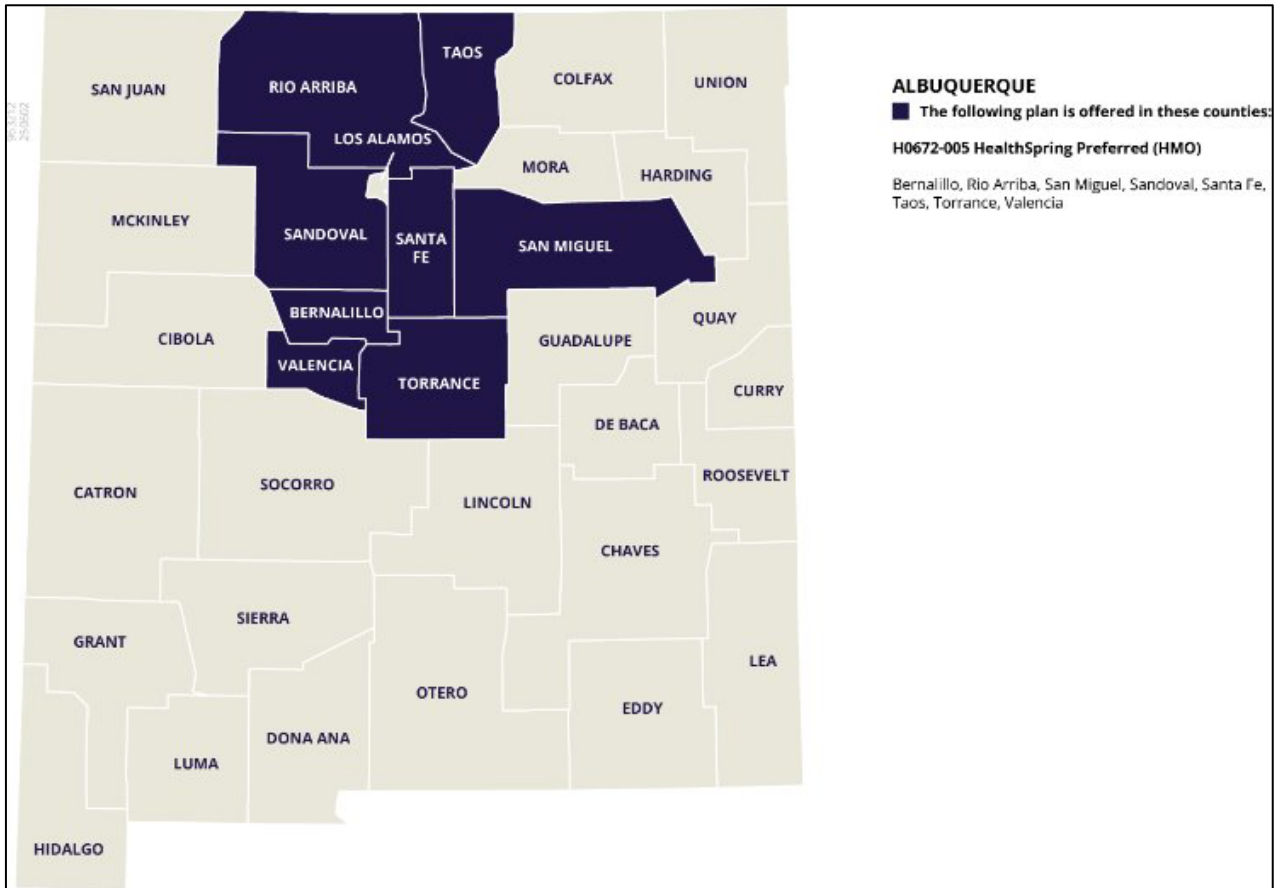
Kansas City



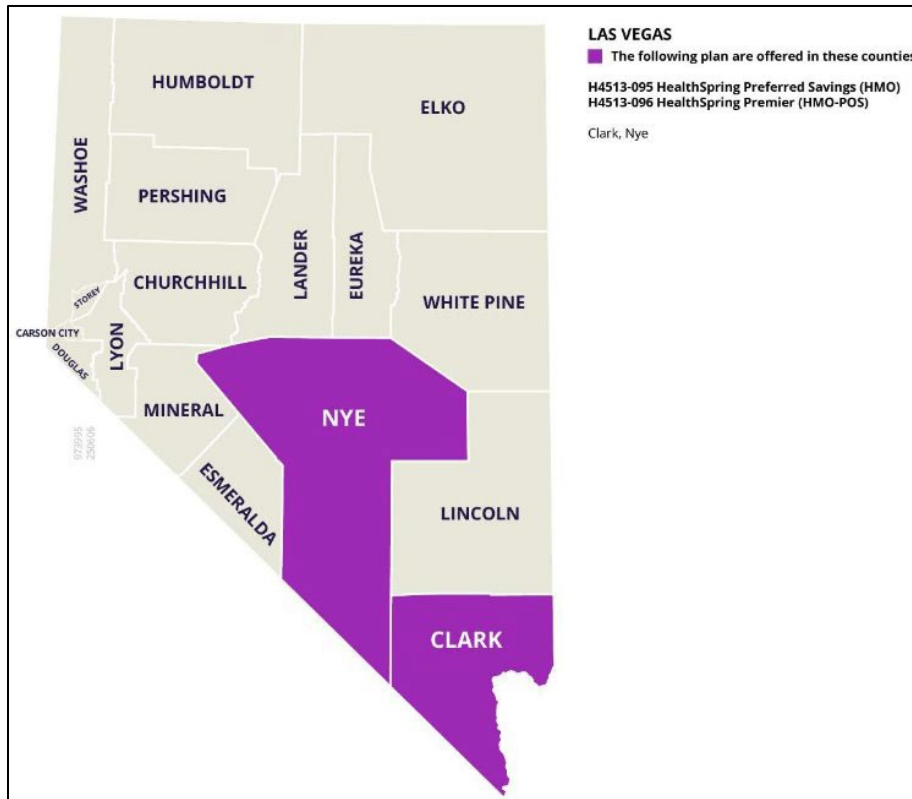
Missouri



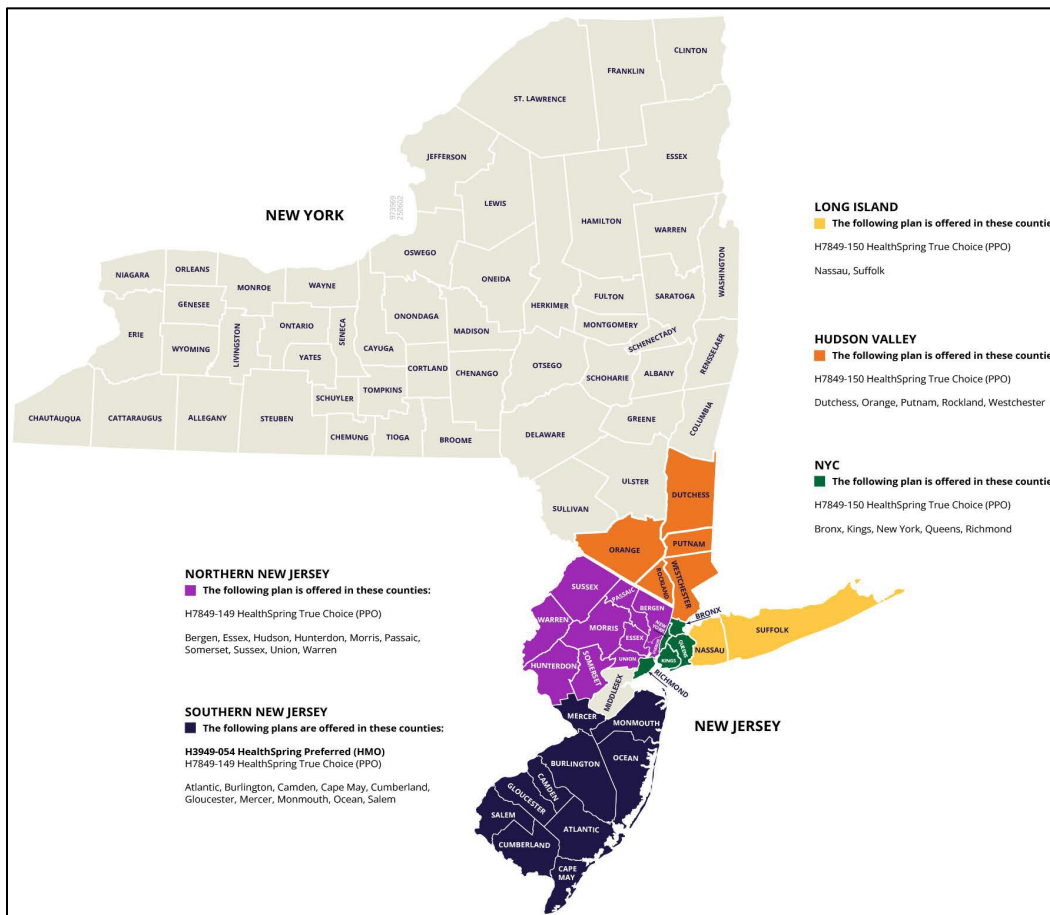
New Mexico



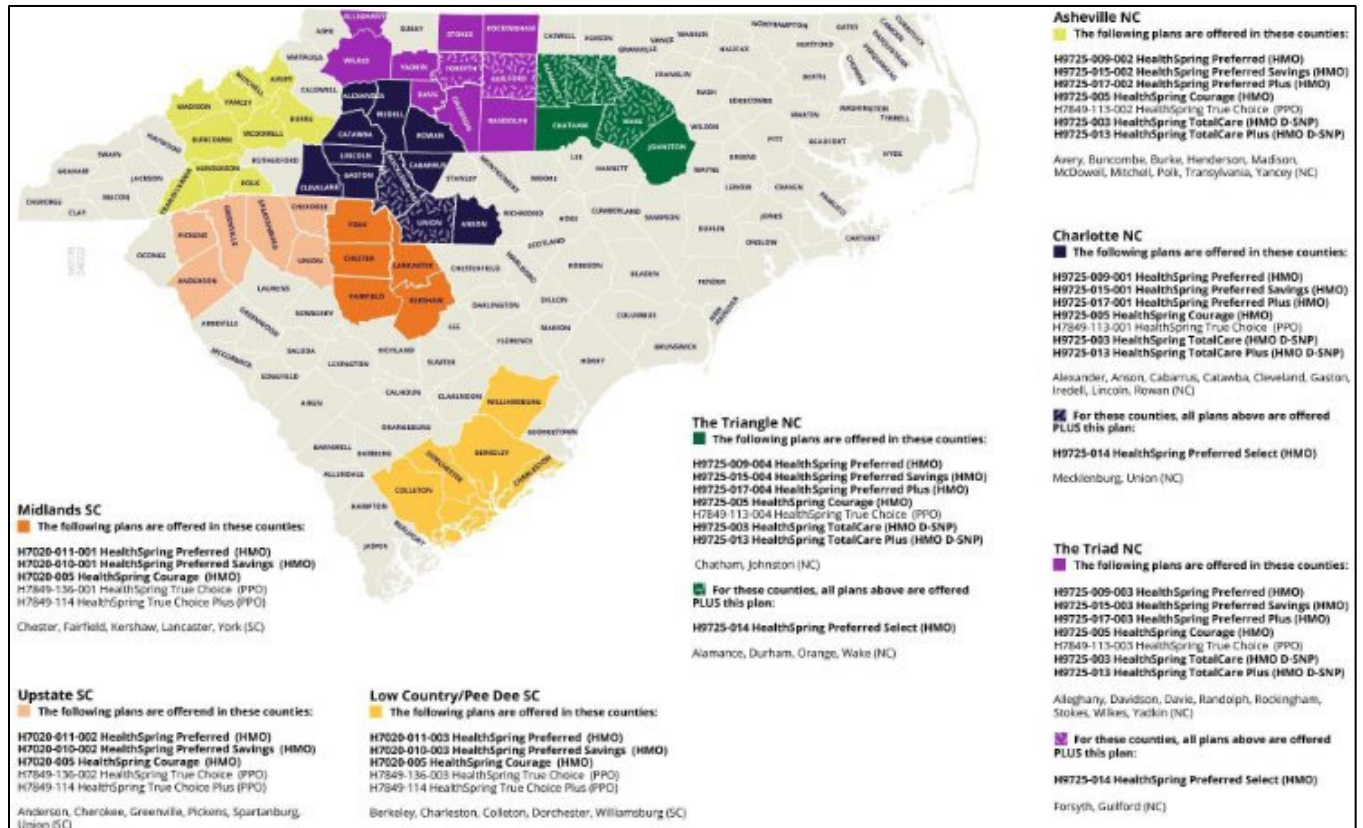
Nevada



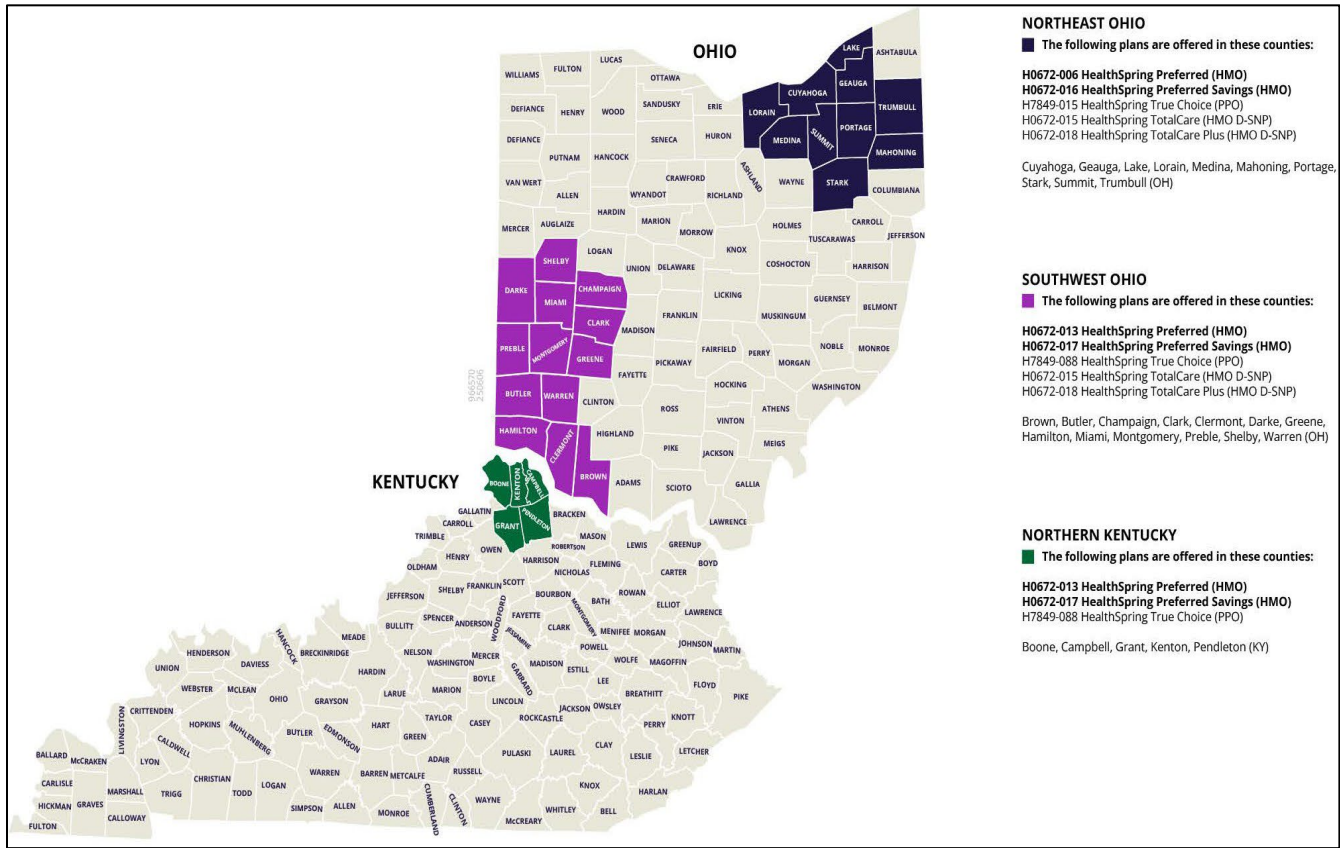
New York and New Jersey



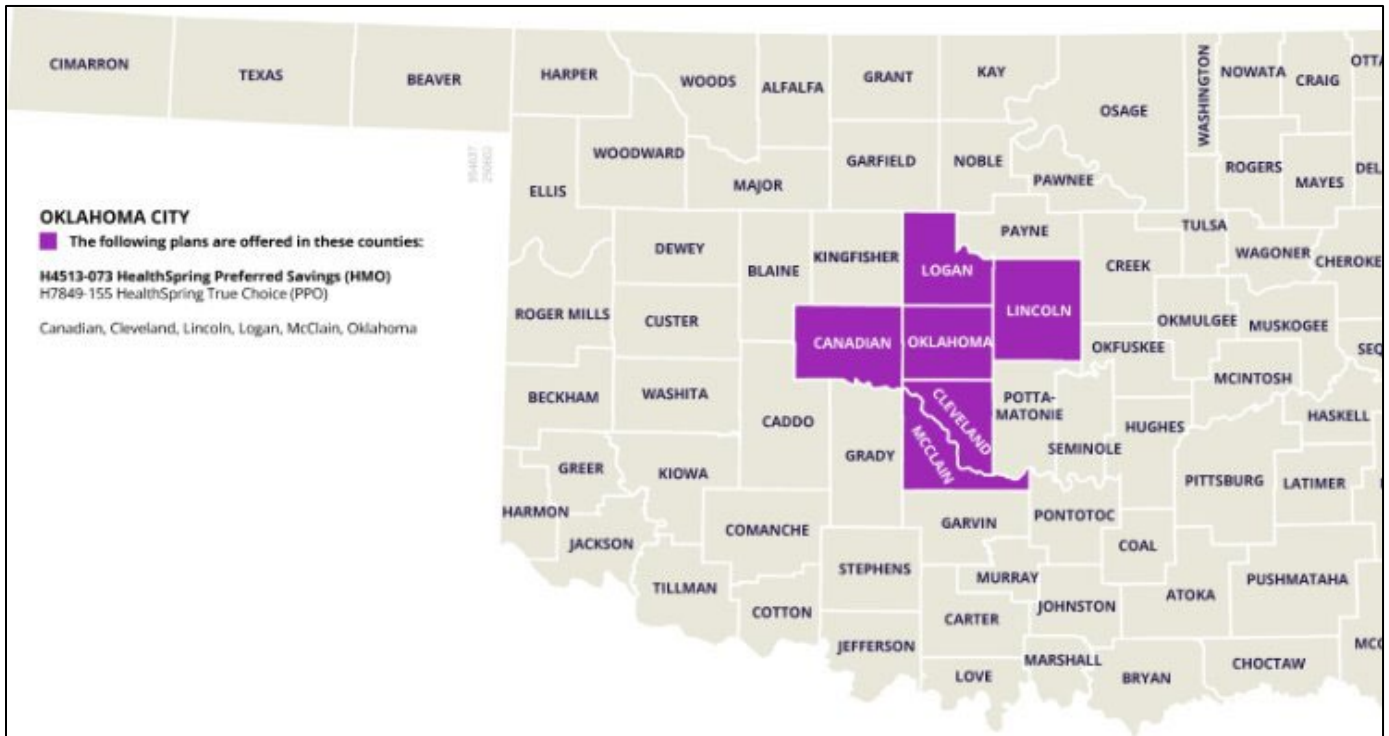
North Carolina and South Carolina



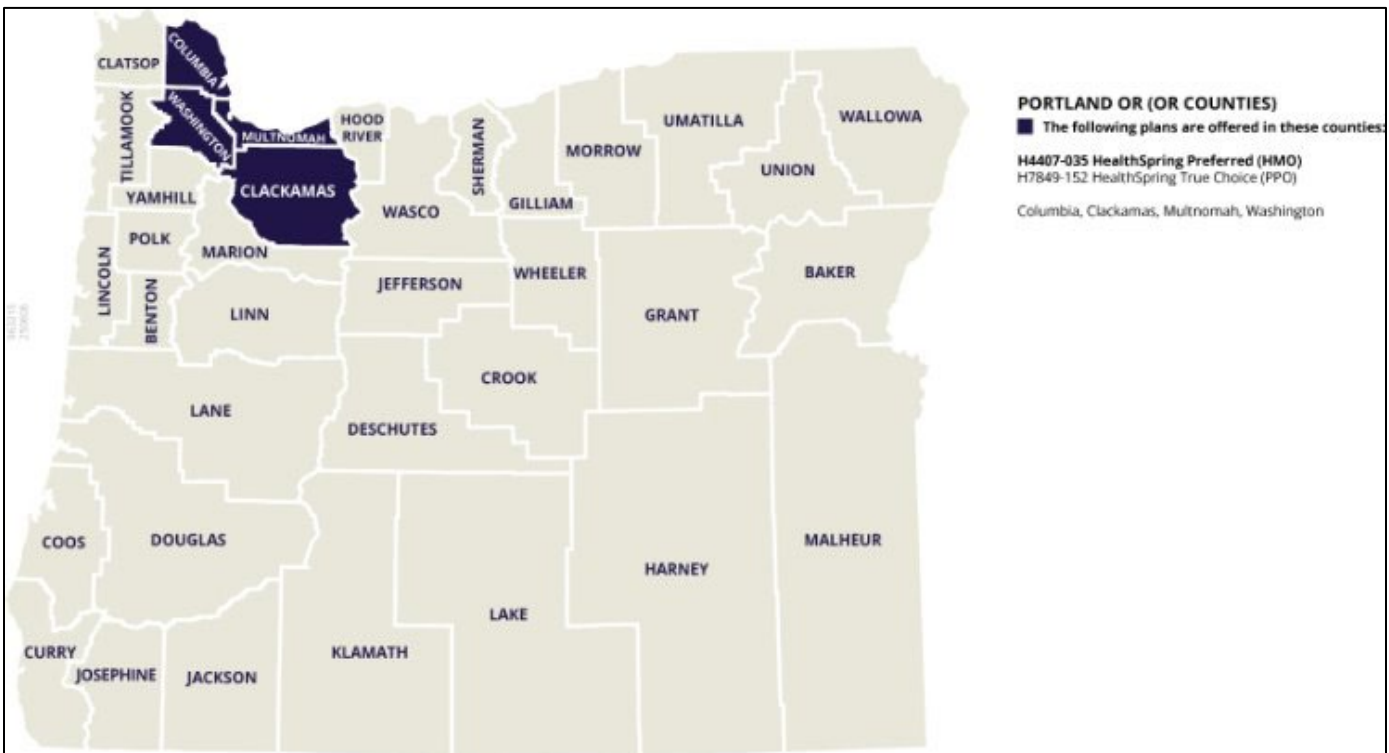
Ohio and Kentucky



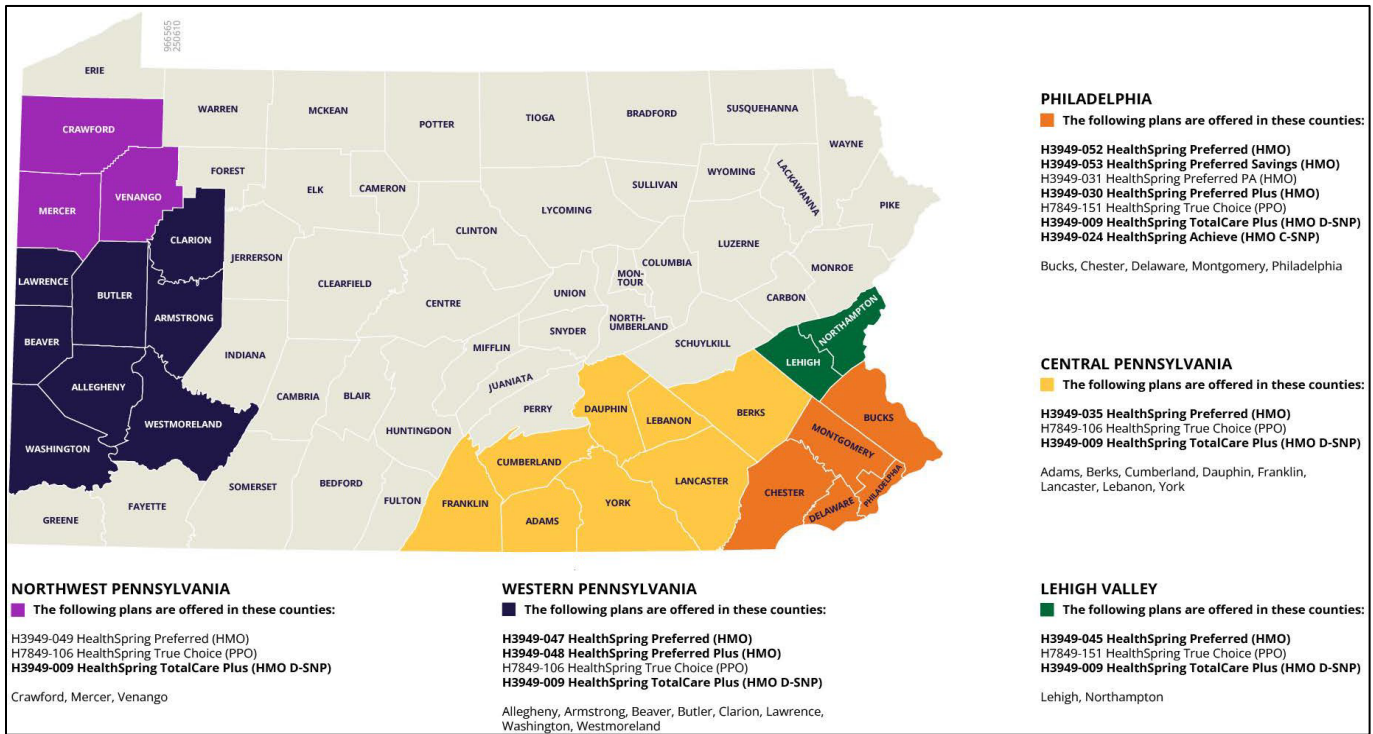
Oklahoma



Oregon



Pennsylvania



Tennessee

West TN
 The following plans are offered in these counties:
 H4513-049-005 HealthSpring Preferred (HMO)
 H4513-036 HealthSpring Premier (HMO-POS)
 H4513-053 HealthSpring Primary (HMO)
 H4513-033 HealthSpring Courage (HMO)
 H7849-153 HealthSpring True Choice (PPO)
 H4513-034 HealthSpring TotalCare Plus (HMO D-SNP)
 Benton, Carroll, Decatur, Hardeman, Hardin, Henderson, Madison, McNairy (TN)
 For this county, all plans above are offered EXCEPT for the Premier plan:
 Haywood (TN)
 For these counties, only the Preferred, Courage and PPO plans are offered:
 Henry, Weakley (TN)
 For these counties, only HMO plans are offered, PPO plan is not available:
 Chester, Crockett, Gibson (TN)
 For this county, only the PPO plan is offered, HMO plans are not available:
 Lake (TN)

Middle TN
 The following plans are offered in these counties:
 H4513-049-002 HealthSpring Preferred (HMO)
 H4513-036 HealthSpring Premier (HMO-POS)
 H4513-033 HealthSpring Courage (HMO)
 H7849-153 HealthSpring True Choice (PPO)
 H4513-034 HealthSpring TotalCare Plus (HMO D-SNP)
 Cannon, Clay, Coffee, Cumberland, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Moore, Overton, Perry, Pickett, Putnam, Smith, Stewart, Van Buren, Warren, Wayne, White (TN)
 For this county, all plans above are offered EXCEPT the Premier plan:
 Bedford (TN)
 For this county, only these plans are offered:
 H4513-049-002 HealthSpring Preferred (HMO)
 H4513-033 HealthSpring Courage (HMO)
 Franklin (TN)

Nashville
 The following plans are offered in these counties:
 H4513-049-001 HealthSpring Preferred (HMO)
 H4513-000 HealthSpring Preferred Full Savings (HMO)
 H4513-068-001 HealthSpring Preferred Savings (HMO)
 H4513-036 HealthSpring Premier (HMO-POS)
 H4513-053 HealthSpring Primary (HMO)
 H4513-033 HealthSpring Courage (HMO)
 H7849-153 HealthSpring True Choice (PPO)
 H4513-034 HealthSpring TotalCare Plus (HMO D-SNP)
 Cheatham, Robertson, Rutherford, Trousdale (TN)
 For these counties, all plans above are offered PLUS this plan:
 H4513-097 HealthSpring Achieve (HMO C-SNP)
 Davidson, Sumner, Williamson, Wilson (TN)
 For this county, only HMO plans are offered, PPO plan is not available:
 Montgomery (TN)

Memphis (TN counties)
 The following plans are offered in these counties:
 H4513-049-004 HealthSpring Preferred (HMO)
 H4513-068-002 HealthSpring Preferred Savings (HMO)
 H4513-036 HealthSpring Premier (HMO-POS)
 H4513-053 HealthSpring Primary (HMO)
 H4513-033 HealthSpring Courage (HMO)
 H7849-153 HealthSpring True Choice (PPO)
 H4513-034 HealthSpring TotalCare Plus (HMO D-SNP)
 Fayette, Lauderdale, Shelby, Tipton (TN)

Knoxville
 The following plans are offered in these counties:
 H4513-037 HealthSpring Preferred (HMO)
 H4513-035 HealthSpring Primary (HMO)
 H4513-033 HealthSpring Courage (HMO)
 H7849-153 HealthSpring True Choice (PPO)
 Anderson, Blount, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Morgan, Sevier, Union (TN)
 For these counties, all plans above are offered EXCEPT the Primary plan:
 Campbell, Claiborne, Hancock, Meigs, Monroe, Rhea, Scott (TN)

Chattanooga (TN Counties)
 The following plans are offered in these counties:
 H4513-049-003 HealthSpring Preferred (HMO)
 H4513-068-003 HealthSpring Preferred Savings (HMO)
 H4513-036 HealthSpring Premier (HMO-POS)
 H4513-035 HealthSpring Primary (HMO)
 H4513-033 HealthSpring Courage (HMO)
 H7849-153 HealthSpring True Choice (PPO)
 H4513-034 HealthSpring TotalCare Plus (HMO D-SNP)
 Bradley, Hamilton, Marion, Sequatchie (TN)
 For these counties, all plans above are offered EXCEPT the Primary plan:
 Bladwell, Polk (TN)
 For this county, all plans above are offered EXCEPT the Premier plan:
 Grundy (TN)

Texas

DALLAS
 The following plans are offered in these counties:
 H4513-061-005 HealthSpring Preferred (HMO)
 H4513-083-005 HealthSpring Preferred Savings (HMO)
 H4513-009 HealthSpring Courage (HMO)
 H7849-154 HealthSpring True Choice (PPO)
 H4513-060-005 HealthSpring TotalCare (HMO D-SNP)
 Collin, Dallas, Denton, Hood, Johnson, Parker, Tarrant, Wise
 For these counties, all plans above are offered PLUS this plan:
 H7877-001 HealthSpring True Choice Savings (PPO)
 Collin, Dallas, Denton, Johnson, Tarrant

NORTHEAST TEXAS
 The following plans are offered in these counties:
 H4513-026 HealthSpring Preferred (HMO)
 H4513-083-006 HealthSpring Preferred Savings (HMO)
 H4513-009 HealthSpring Courage (HMO)
 H7849-154 HealthSpring True Choice (PPO)
 H4513-027 HealthSpring TotalCare (HMO D-SNP)
 Gregg, Harrison, Henderson, Rusk, Smith, Upshur, Van Zandt

HOUSTON
 The following plans are offered in these counties:
 H4513-061-001 HealthSpring Preferred (HMO)
 H4513-083-001 HealthSpring Preferred Savings (HMO)
 H4513-009 HealthSpring Preferred Full Savings (HMO)
 H4513-009 HealthSpring Courage (HMO)
 H7849-154 HealthSpring True Choice (PPO)
 H4513-060-001 HealthSpring TotalCare (HMO D-SNP)
 Argelia, Jasper, Nacogdoches, Polk, San Jacinto, Walker
 For this county, all HMO plans above are offered, the PPO plan is not available:
 Tyler
 For these counties, all plans above are offered, PLUS this plan:
 H4513-064 HealthSpring Alliance (HMO)
 Brazoria, Fort Bend, Galveston, Hardin, Harris, Jefferson, Liberty, Montgomery, Orange
 For these counties, all HMO plans above are offered, the PPO plan is not available:
 Chambers, Walker

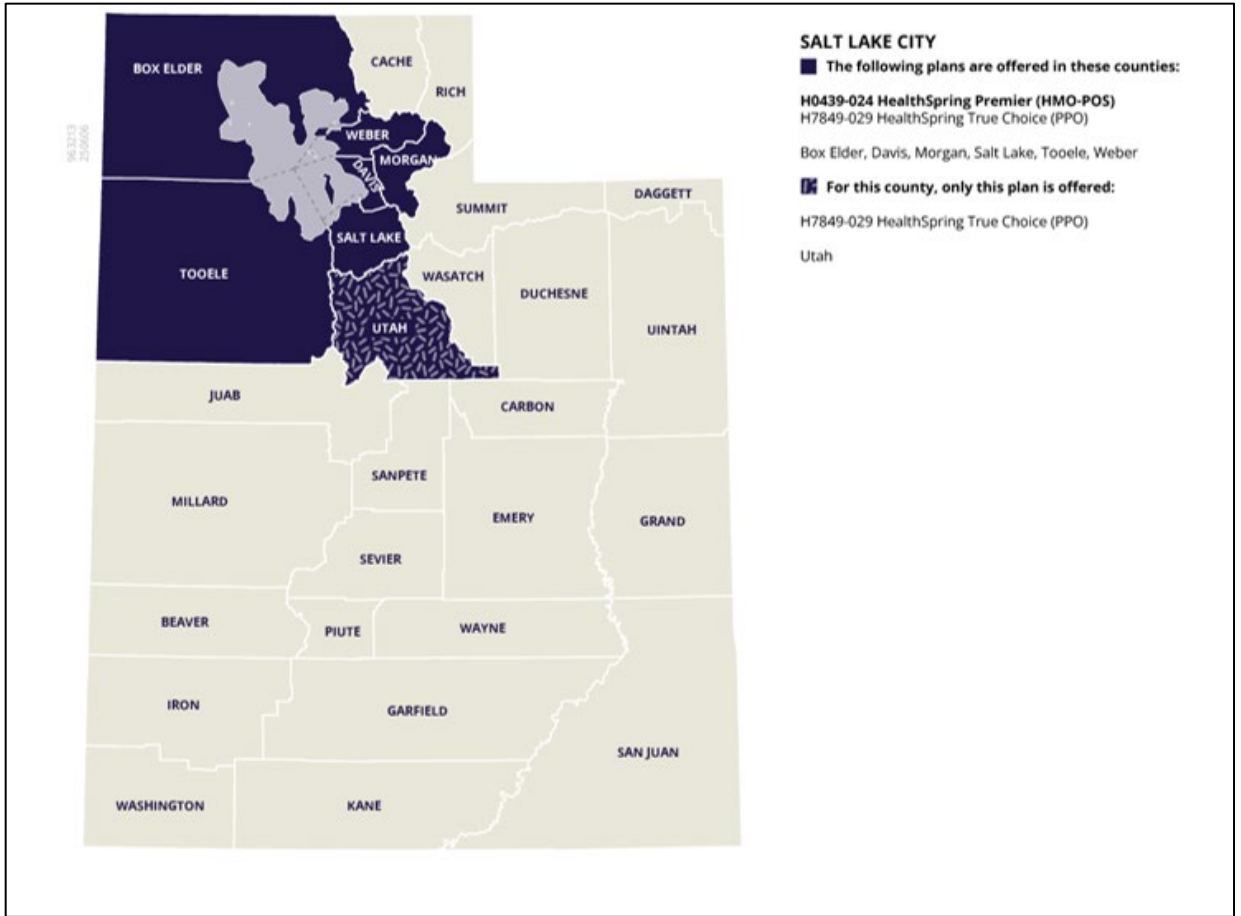
SAN ANTONIO
 The following plans are offered in these counties:
 H4513-061-004 HealthSpring Preferred (HMO)
 H4513-083-004 HealthSpring Preferred Savings (HMO)
 H4513-009 HealthSpring Courage (HMO)
 H4513-060-004 HealthSpring TotalCare (HMO D-SNP)
 Comal, Guadalupe
 For these counties, all plans above are offered PLUS this plan:
 H7849-154 HealthSpring True Choice (PPO)
 Atascosa, Bandera, Bexar, Kendall, Medina, Wilson

CORPUS CHRISTI
 The following plans are offered in this county:
 H4513-074 HealthSpring Preferred (HMO)
 H4513-083-007 HealthSpring Preferred Savings (HMO)
 H4513-009 HealthSpring Courage (HMO)
 H4513-075 HealthSpring TotalCare (HMO D-SNP)
 Atascosa
 For this county, all plans above are offered PLUS this plan:
 H7849-154 HealthSpring True Choice (PPO)
 Nueces

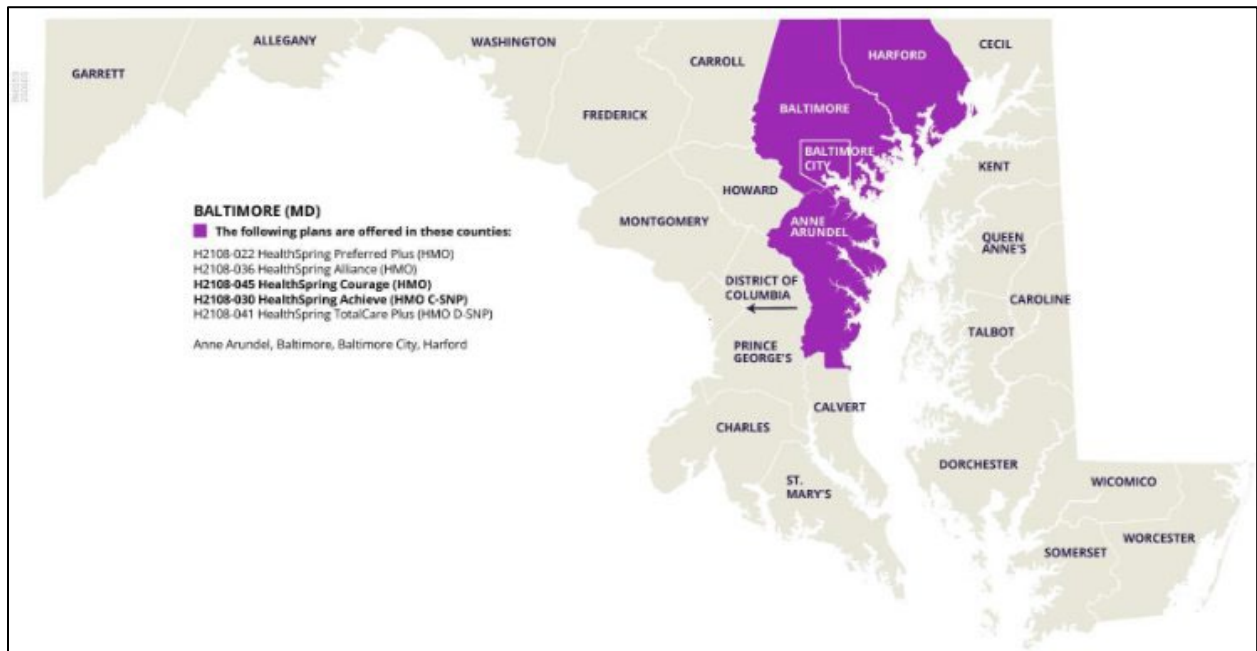
EL PASO
 The following plans are offered in this county:
 H4513-061-003 HealthSpring Preferred (HMO)
 H4513-083-003 HealthSpring Preferred Savings (HMO)
 H4513-009 HealthSpring Preferred Full Savings (HMO)
 H4513-009 HealthSpring Courage (HMO)
 H7849-154 HealthSpring True Choice (PPO)
 H4513-060-003 HealthSpring TotalCare (HMO D-SNP)
 El Paso

VALLEY
 The following plans are offered in these counties:
 H4513-061-002 HealthSpring Preferred (HMO)
 H4513-083-002 HealthSpring Preferred Savings (HMO)
 H4513-002 HealthSpring Preferred Full Savings (HMO)
 H4513-009 HealthSpring Courage (HMO)
 H7849-154 HealthSpring True Choice (PPO)
 H4513-060-002 HealthSpring TotalCare (HMO D-SNP)
 H4513-008 HealthSpring Achieve (HMO C-SNP)
 Cameron, Hidalgo, Webb, Willacy

Utah



Virginia



Washington and Oregon (Pacific Northwest)

