Dear Valued Provider,

Welcome to QualCare, Inc.!

The primary objective of QualCare is to provide high quality medical care in a cost-effective environment. Success in the QualCare mission of providing quality medical care, while at the same time managing rising health care costs, depends upon your support and involvement in this unique health care alternative.

The QualCare network offers self-insured employers and fully insured carriers a full range of services to choose from, including network access and management, provider credentialing, Third Party Administrator services, claims processing, Population Health Management including Utilization Management, Case Management, Disease Management and Quality Improvement. QualCare offers clients a full range of Managed Care Products to choose from, including HMO/POS Network, PPO Network and Workers’ Compensation Network access.

This provider manual is designed to provide participating providers and their office staff a source of readily available information regarding the administrative processes for providing care to QualCare members. From time to time there may be new client information or changes in established policies and procedures. We will let you know about these changes as quickly as possible to ensure proper administration. You may access provider news and information at www.qualcareinc.com. We continue to add new features and information to our web site, so check back often. And, if you don’t find the information you are looking for, use the email address to our Provider Services Department, qcprovrel@qualcareinc.com.

QualCare currently provides services to over 900,000 covered lives in all twenty-one counties in the state of New Jersey. Our network includes over 40,000 physicians and health care professionals as well as 100 acute, specialty and rehabilitation hospitals. Please access our on-line Provider Directory to check your own listing for accuracy. If any corrections are necessary, please notify QualCare’s Provider Relations Department.

We are committed to ensure that your participation in QualCare is a positive and beneficial experience. Therefore, please feel free to contact QualCare’s Provider Relations Department at 1-800-992-6613 if you have any questions or concerns. QualCare personnel will work closely with you to answer your questions or resolve any problems you may encounter.

Thank you for your participation. We look forward to working with you and your office staff.
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Note: QualCare may or may not process the claims and act as TPA for a client. For best results, follow the contact information on the back of the members’ ID card.

Corporate Mailing Address:

QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854

Corporate Main Number: 800-992-6613 or 732-562-0833

Claims Address:
Please forward claims to address on back of ID card or electronically using the payor ID number.

Directory of Participating Providers
QualCare’s comprehensive network ensures QualCare members that their medical needs will be provided for in a continuous and coordinated manner in the hands of skilled physicians, quality ancillary providers, and well-established hospitals.

QualCare produces a Provider Directory that lists all participating providers by specialty, county, and city. This directory is conveniently accessible through the internet at www.qualcareinc.com. The internet directory is updated daily and provides the fastest, most convenient way to access up-to-date network information.

Eligibility Information - Integrated Voice Recognition (IVR) System / NaviNet
For members where QualCare manages enrollment information, you can verify eligibility or inquire on claim status online via NaviNet (https://navinet.navimedix.com) or telephonically via our Integrated Voice Recognition (IVR) system 24 hours a day, seven days a week. Please call 1-800-992-6613 and follow the prompts. For all others, please call the number on the back of the member ID card.

Member Services Department
For questions about Benefits and/or Policy and Procedures, you can either call the number listed on the back of your patient’s card or call the Member Services Department at 1-800-254-0130.

Provider Relations Department
The Provider Relations Department is available to provide assistance telephonically and in person. The Department’s expertise is in the areas of:

- Training Assistance for Office Staff
- Supplies and Forms
- Claims Submission Process

Please call 1-800-992-6613 for assistance.
Population Health Management (Utilization Management)

Population Health Management can be defined as a system of preadmission, concurrent and retrospective review of inpatient and outpatient healthcare services along with Case Management of catastrophic cases and Disease Management of specific chronic diseases. The Population Health Management Program incorporates all of these activities in an effort to control the costs of healthcare while assuring the provision of quality care in accordance with local, state and national standards. The primary components of the Population Health Management Program are:

- Pre-certification of inpatient and key outpatient services;
- Telephonic Concurrent Review;
- Case Management of short term and long term catastrophic cases; (please contact the number below for referrals)
- Discharge planning;
- Coordination of out-patient services;
- Disease Management; (please contact the number below for referrals)
- UM Quality Review;
- Mental Health/Substance Abuse Review.

Please call the number on back of the member’s identification card or 800-992-6613 and follow the prompts to the Population Health Management (Utilization Management Department). Follow the prompts for Pre-certification, Case Management, or Disease Management.

The Utilization Management staff is available during normal business hours from 8 am- 6 pm (Eastern Standard Time) to answer inbound calls; voicemail messages can be left outside normal business hours for QualCare designated fully insured Clients. The UM staff has access to a language line to assist the linguistically diverse population, as well as TDD to assist the deaf population. The UM fax lines are open 24 hours a day, 7 days a week to receive inbound communication.

Workers’ Compensation:

As a certified Workers’ Compensation Managed Care Organization, QualCare provides carriers and self-funded companies complete managed care services with a focus on high quality, cost effective care for the occupationally injured.

Workers’ Compensation Department: 1-800-425-3222.

The Network

QualCare History and Overview

QualCare is among New Jersey’s largest Managed Care Organizations started by provider sponsors. It is our mission to provide access to the best health care available in the state of New Jersey, in a cost effective and responsible manner.

QualCare was founded as a Preferred Provider Organization by an alliance of hospitals and physicians and is now one of the largest networks and organized delivery system in the state of New Jersey. QualCare’s predecessor company, Preferred Providers of New Jersey, Inc. (PPNJ) was founded in 1991 by SSM Health Care Ministry Corporation and St. Clare’s Physician Organization, Inc. PPNJ was a start-up PPO that served the employees of St. Clare’s Riverside Medical Center in Morris County.

In 1993, PPNJ added five new sponsor hospitals to its provider network and expanded its membership to cover the employees and dependents of these additional hospitals. In 1994, the company expanded its customer base to include small and medium sized self-insured employers and expanded the hospital and provider network to include non-sponsor hospitals and physicians. In 1995, PPNJ was liquidated and the sponsors incorporated QualCare as a New Jersey for-profit corporation. QualCare is now a wholly-owned subsidiary of Cigna Health and Life Insurance Company.

Today the QualCare network of participating providers includes 100 acute, rehabilitation, and specialty hospitals in New Jersey, and more than 40,000 physicians and ancillary providers. Providers may choose to participate in QualCare’s PPO Network, HMO/Point of Service Network, and/or Workers’ Compensation products.

Through our Network and Organized Delivery System, QualCare makes affordable, quality health care available to employers who choose to self-fund their employees’ health insurance, and to carriers who want a comprehensive network of top notch providers with reasonable, fair, and effective management services. QualCare now proudly covers approximately 900,000 lives through its group health and workers comp products.

QualCare offers clients the complete package of services including:

- Plan design and administration
- Claims administration
- Network Access
- Population Health Management
- Accountable Care Organization (ACO) Solutions

Our clients are free to choose which services we will provide for them, so it is important that our providers reference the members’ ID card for eligibility, utilization management, and claims questions. Of course, our provider services department is always available help to facilitate getting answers to your questions should you encounter any difficulties.
Our Agreement:

Participating providers are those physicians, allied health providers, hospitals and facilities who have entered into a provider agreement with QualCare, Inc. As a participating provider you join other providers committed to working toward a positive and mutually beneficial business relationship with QualCare, Inc.

This QualCare Provider Manual is intended for the sole use of QualCare participating physicians, ancillary and allied health providers, hospitals, and other facilities for administrative and information purposes only.

Your responsibilities and agreements as a participating provider are defined in your provider agreement. Always refer to your agreement when you have a question about the obligations which you each bear. The information below is a brief highlight of our respective commitments.

QualCare Commits That:

- We will work with our providers and clients to collaborate on the response to public concern over health care costs;
- Offer products that allow our subscribers the freedom to choose their providers;
- Offer products that provide strong incentives to see providers within the Network;
- Lead and support realistic cost-containment initiatives without sacrificing quality;
- Strive to balance the need for equitable reimbursement for our providers while providing predictable medical costs to our clients.
- We will work to provide the best service we possibly can to our providers and our membership. We equally value these relationships and recognize the needs for both must be met for our on-going success.

Our Participating Providers Commit To:

- To see and treat QualCare members within the prescribed access standards and with the same regard and diligence as all other patients;
- Accept the QualCare allowed rates as payment in full for all covered services;
- To submit complete and timely claims;
- An obligation to work cooperatively and collaboratively with QualCare and Client cost containment programs including preauthorization or certification, concurrent review, and case management.
- To cooperate with all Quality Management programs.
- Making decisions regarding healthcare services under the following provisions:
  - Utilization Management decision making is based only on appropriateness of care and service and the existence of coverage.
  - QualCare does not specifically reward practitioners or other individuals for issuing denials of coverage.
  - Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.
    - The nurses, physicians, other professional providers, and independent medical consultants who perform utilization review services for the Plan are not compensated or given incentives based on their coverage review decisions. There are no financial incentives for such individuals that would encourage utilization review decisions that result in underutilization.
Provider Credentialing and Recredentialing:

QualCare will consider all providers for participation without regard to race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve/national guard or any other similarly protected status.

QualCare stipulates mandatory credentialing for all licensed healthcare providers prior to participation in the QualCare Network.

QualCare adheres to NCQA standards, N.J.A.C.11:24A-4.7, N.J.A.C. 11:24-3.9 for credentialing providers. Additionally, for all providers:

- Credentialing and recredentialing policies and procedures are adopted by the Credentialing Committee and Quality Management (QM) Committee, reviewed annually and revised, as needed.

- QualCare demonstrates adherence to policies and procedures regarding provider compliance, termination and appeal processes.

- QualCare adopts guidelines for the initial credentialing and recredentialing of ancillary facilities and providers.

- The credentialing process includes an initial completed application, (CAQH accepted) and approval/denial process. The following documents are required, to be included, by the Provider, as part of the completed application:

  a) Signed and dated application/re-credentialing application.
  b) Education and training
  c) Work history/CV - including start and end dates and an explanation of any gaps longer than six months.
  d) Licensure – Legible copy of unrestricted current NJ State and all other applicable State Licenses
  e) DEA Registration – Legible copy of current DEA Registration
  f) CDS Registration – Legible copy of current CDS Certificate
  g) Malpractice Coverage – Legible copy of current malpractice face sheet with coverage of $1M per occurrence and $3M aggregate.
  h) Board Certification (if applicable) – Legible copy of Board Certificate, if applicable
  i) Hospital Privileges – indicates primary admitting hospital and all other admitting hospitals if applicable. Hospital privileges must be at a QualCare participating hospital.
  j) Disclosure questions - must accurately and fully answer the questions, regarding malpractice history; ability to perform functions; history of any loss of license and/or felony convictions; history of loss or limitations of any privileges; history/disclosure of substance abuse or addiction problems.
  k) Statement of Collaboration required for all Nurse practitioners, Physician Assistants and Nurse Midwives.
The Credentialing Department performs all primary source verification accessing national databases approved by NCQA. Verification is performed on the above required documents, plus sanctions and malpractice history.

Required documents must be no older than 180 days.

All malpractice cases, adverse NPDB responses, adverse notifications received from other sources and site-visit issues are reviewed and forwarded to the Medical Director. The provider applicant is contacted, as needed, to supply additional information, clarify data inconsistencies or correct any erroneous information. The provider has the right to review information submitted to support the credentialing, application and request status of their application at any time.

All information obtained for credentialing purposes during the credentialing process will be kept confidential and may be reviewed by you within the scope of QualCare’s policy and procedures at QualCare’s corporate office, by sending a request in writing to the Credentialing Department.

All completed application packages are reviewed by the Credentialing Committee, which is comprised of staff and non-staff physicians. The files are accepted, denied or tabled for additional information. Accepted files are presented to the Quality Management (QM) Committee. A representative from the QM Committee presents approved files to the Board of Directors. Tabled files are updated before being presented at the next Credentialing Committee. Denied applicants may apply again in 12 month.

The Credentialing department notifies all providers of their acceptance or denial into the QualCare Network within 60 days of the credentialing committee’s decision. All providers have the right to appeal Credentialing decisions upon written notification.

**Re-credentialing Process**

All providers in QualCare are recredentialled every three years from initial acceptance into the QualCare Network. Continuation of participation is dependent upon successful completion of the recredentialing process. Providers who are non-compliant with recredentialing will be non-renewed.

**NOTE:** Policy exceptions include, but are not limited to, providers that are 100% hospital based. Examples of these exceptions are emergency medicine providers, radiologists, pathologists, anesthesiologists and any other specialty that is 100% hospital based.

The recredentialing procedure follows the Credentialing Process, as documented above.
QualCare Group Health Products:

QualCare provides self-funded employers and carriers a comprehensive offering of plans to choose from. Each of these is described below:

Preferred Provider Organization (PPO) Plan:
QualCare PPO plans provide a managed care system in which the members are able to choose from our comprehensive network of doctors, hospitals, and ancillary facilities that provide care according to a set fee schedule. Members are given a strong financial incentive to use providers in the PPO network, but have the freedom to choose out of network providers at a higher out of pocket expense. The basic PPO plan has two levels of benefits, an in-network and an out-of-network benefit. If a network provider is chosen, the plan pays at a higher benefit level. Typically plans will have a deductible associated with out-of-network services.

Many of our hospital clients have added a third level of benefit to their plans. This structure provides for the highest level of in-network benefit being paid if the member seeks care from the hospital employer and/or the hospital employer’s affiliated physicians. A second, moderately reduced level of in-network benefit is provided if the member sees a participating QualCare provider. Lastly, these plans also typically offer the significantly reduced out-of-network benefit.

Health Maintenance Organization (HMO) Network Plans:
The QualCare HMO Network is a managed care plan in which a Primary Care Physician (PCP) manages the total health care of the individuals covered under the plan. It is a closed network of providers where the members can access, and must always receive referrals from their PCP to receive benefits, except in cases of emergency. PCPs must refer to in-network providers. The HMO Network health plan places emphasis on maintaining the good health of its members with the goal of controlling health care costs by preventing illness. Patients choose their PCP who will then coordinate their care. It is the role of the PCP to decide what health services are needed and when. QualCare PCP’s are paid on a fee-for-service basis as opposed to capitation.

It is important to remember that with the HMO Network, there is only one level of benefit. If a member accesses care outside of the HMO Network, there are no benefits available and the member will be responsible for the charges incurred.

Health Maintenance Organization (HMO) Network Open Access
Same benefit design as the HMO Network except members do not need a referral to see a specialist. However, members may or may not have to choose a PCP.

Point of Service (POS) Plans:
QualCare POS plans are less restrictive and combine the benefits of an HMO model with aspects of a PPO plan. With the POS plan, the member chooses a PCP to manage their care. The benefit structure encourages the member to take an active role in managing their health care costs by always accessing their health care through their PCP. The PCP has a responsibility to refer the member to in-network specialists when the member accesses services through them and requires additional services. However, the POS plan differs from the HMO model in that it maintains a freedom of choice for the member to choose to see an out-of-network provider without a visit to the PCP or a referral of any kind at a reduced benefit level. To encourage members to access
through their PCP, plans are typically structured with an out-of-network deductible which must be met before benefits are paid for covered services.

**Open Access (POS) Plans:**
POS Open Access plans give members the most flexibility over managing their costs and access.

Same as HMO Network. The member can visit any in-network or out-of-network specialist without a referral. Costs to the member will be lowest when they seek care from in-network providers. Out-of-network deductibles typically must be met before benefits are paid for covered services. The member may not be required to choose a PCP in the Open Access Plan, but it is strongly recommended.

**Direct Access:**
Same as Open Access, except no PCP is required.

**QualCare Typical Plan Reference Guide***

*The information provided reflects usual plan structure. Additions and notifications will be provided if and when a plan substantially differs.

The member’s identification card must be checked to determine if referrals are needed or a PCP required.

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<th>OPEN ACCESS</th>
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<td>PCP</td>
<td>Not Required</td>
<td>Required</td>
<td>Required</td>
<td>Optional</td>
</tr>
<tr>
<td>Referral</td>
<td>Not Required</td>
<td>Required some of the time, check member’s ID Card to verify if referral is required.</td>
<td>Required for In-Network Services. Members may access out of network without PCP visit or referral.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Out-of-network benefit</td>
<td>Yes, higher out of pocket expenses</td>
<td>No, no benefits are paid for out-of-network care</td>
<td>Yes, higher out of pocket expenses</td>
<td>Yes, higher out of pocket expenses for POS. No for HMO Network.</td>
</tr>
<tr>
<td>Preauthorization requirements</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Co-pay</td>
<td>Yes, Plan and service specific</td>
<td>Yes, Plan and service specific</td>
<td>Yes, Plan and service specific</td>
<td>Yes, Plan and service specific</td>
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Payors and Carriers who access the QualCare networks may have contracted with QualCare or with an alternate vendor to process claims and provide utilization management services. When members have access to the QualCare network, the appropriate QualCare logo will appear on the member’s ID card. Providers can refer to the Payor or Carrier for their specific policies and procedures. Where there are differences between the information found on a Payor or Carrier’s provider manual and the QualCare provider manual, the QualCare provider manual will supersede those differences. For questions or general inquiries regarding Carriers or Payors accessing the QualCare Network, contact Customer Service at 1-800-992-6613.

For Oscar’s provider manual, refer to: https://provider.hioscar.com/resources/new-jersey/Overview/

**Benefit Coverage, Exclusions and Limitations**

**Covered Services**

In general, the following services are covered under the health benefit plans served by the QualCare Network. A full description of these services and a complete list of other covered services are included in the member’s Evidence of Coverage or Summary Plan Description document. Some services have limitations on the number of visits; please verify those limitations by calling the number on the back of the member’s identification card.

1. Examinations and office visits with the member’s Physician for routine and preventive care.
2. Lab and radiology services, when referred/requested by the member’s PCP (for HMO/POS products).
3. Prenatal and obstetric care, including, but not limited to 48 hours of inpatient care following a vaginal delivery and 96 hours of inpatient care following a Caesarean section, if the physician determines this is necessary or the physician requests it. Home visits are covered for mothers who request them and opt for an earlier discharge.
4. Direct access to Obstetrical and Gynecological (OB/GYN) services (prior authorization from PCP/referral not required).
5. Regular pediatric care, including newborn care and immunizations by the PCP.
6. Radiation therapy, as authorized.
7. Consultations and specialists’ services, as requested by the PCP.
8. Supportive and health promotion, including preventive exams, diagnostics (including but not limited to mammograms, pap smears, colon rectal exam)
9. Rehabilitative therapies, including physical, occupational, speech, cardiac and cognitive therapies with Plan specific limits.
11. Outpatient evaluative, crisis intervention and mental health services.
12. Outpatient substance abuse care.
13. Basic eye care provided by participating optometrists and, when medically appropriate, by ophthalmologists.
14. Children’s eye exams provided during a pediatric well child visit to determine the need for vision correction.
15. Inpatient hospital care, including a semi-private room accommodation, physicians’ and surgeons’ services, anesthesia, diagnostic services, as certified by the member’s PCP, or a specialist, to whom the member has been referred by the PCP.
17. Inpatient psychiatric and substance abuse care Plan specific limits.
18. Skilled Plan specific visit limits Home Health Care Plan specific limits.
19. Hospice care from a Medicare-certified hospice agency, up to 180 days with pre-certification.
20. Treatment for Wilm’s tumor.
21. Prescription drugs, if included in the member’s Evidence of Coverage.
22. Other services, as may be required by the NJ Department of Banking and Insurance, or the NJ Department of Health, from time to time.

**IMPORTANT:** This information is provided to serve only as a general guideline and can change from health plan to health plan. To confirm what is covered under your patient’s plan design, please call the number listed on the back of their member card.

**Non-Covered Services**

Following is a partial list of expenses not covered under most health benefit plans served by the QualCare Network. For complete information, please call the number for member services benefit and eligibility information listed on the back of member ID card.

1. Acupuncture, except where otherwise stated in the policy
2. Biofeedback
3. Elective ambulance service, including ambulance service to home after discharge
4. Blood or blood plasma replaced by or for a member
5. Cosmetic surgery, unless it is used to correct a developmental or congenital functional defect or repair an illness or injury sustained while covered under the plan
6. Custodial or domiciliary care
7. Dental care or treatment, including dental appliances, except as stated otherwise in the Member’s Evidence of Coverage or Summary Plan Description.
8. Educational service or supplies designed to provide the member with any of the following: instruction in scholastic skills such as reading, occupational training, or treatment for learning disabilities
9. Experimental or investigational treatments
10. Extraction of teeth, except for bony impacted teeth
11. Services or supplies provided by one of the following members of the member's family: Spouse, child, parent, in-law, brother, sister or grandparent
12. Services or supplies for or in connection with:
   a. Eyeglasses or lenses of any type except initial replacement for loss of natural lens; or
   b. Eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring)
13. Hearing aids
14. Herbal medicine
15. Hypnotism
16. Services or supplies for an injury or illness sustained while the member engaged or tried to engage in an illegal occupation, or committed or tried to commit a felony or crime
17. Work-related injuries or illness
18. Illness or injury sustained while working or when covered under Workers’ Compensation.
19. Separately billed anesthesia, or local anesthesia, if charges are included in the surgical fee
20. Growth hormones and implantable drugs, unless medically necessary and appropriate
21. Membership in health clubs, weight loss clinics, and similar programs
22. Marriage, career or financial counseling, sex therapy or family therapy and related services
23. Methadone maintenance
24. Wigs, toupees, hair transplants, hair weaving or any drug used in connection with baldness
25. Services or supplies for, or in connection with eye surgery, such as radial keratotomy, in which the purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring)
26. Routine foot care, except for: An open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; the removal of nail roots; and the treatment or removal of corns, calluses or toenails in connection with the treatment of metabolic or peripheral vascular diseases
27. Non-prescription drugs or supplies, including, but not limited to colostomy bags, bandages, elastic stockings, splints, braces, dentures, and artificial aids, unless confined to an inpatient setting or prescribed by a physician
28. Personal convenience or comfort items

**Member Information:**

**Identifying QualCare Group Health Members:**

Each QualCare member is given an identification card which will include:

- QualCare logo or identifying mark
- Member’s name
- Unique Member Identification Number
- Member’s Group Number
- Member's Health Benefit Plan
- Co-Pay amount, if applicable
- Telephone number to verify eligibility and coverage
- Telephone number to call for pre-certification
- Mailing address for claims submission and NEIC payor code for claims submission or transmission (it is important to note claims submission addresses may vary according to applicable health benefit plan)
- Workers’ Compensation members may not have an ID card at the time of service due to the nature of injury or illness

Please photocopy both the front and back of the ID card and place the copy in the patient's chart. It is recommended that the Member ID card is requested each time the Member presents to capture any changes. Possession of an ID card does not guarantee eligibility for benefits. It is the provider’s responsibility to:

- Verify benefits and eligibility
- Collect applicable co-payments
- Call for authorization before performing procedures requiring pre-certification
- Submit all claims and/or encounter data to the appropriate address

**Sample ID Cards:**

**Sample HMO Network ID Card:**
Sample of HMO Open Access Network ID Card:

Sample of Point of Service (POS) Network ID Card

Sample Open Access Point of Service (POS) Network ID Card:

Sample PPO Network ID Card
Members Who Present Without an ID Card

While members are advised to always present their ID card when receiving services, there may be unavoidable instances where a member does not have the ID card with them at the time of service.

Information for benefits and eligibility may be obtained by calling the QualCare Automated Customer Service system at 1-800-992-6613, and follow the prompts or visit NaviNet online at [https://navinet.navimedix.com/](https://navinet.navimedix.com/). While QualCare may not manage the eligibility and enrollment information for a particular client, QualCare staff is always more than happy to assist and direct our providers to the proper resources.

Temporary Identification

The coverage of a member may, on occasion, become effective before the ID card has been issued. In these cases, a member may present his/her enrollment form, which will indicate PCP selections for the family if applicable. Please allow these enrollment forms and the information provided on the form to serve as temporary identification.

Members Appeals Process

All Members have a right to appeal through QualCare or their Carrier. Dissatisfied members are encouraged to call or write regarding their concerns about insurance benefits, the QualCare provider network, and utilization management decisions. Contact information regarding where to direct complaints is available by calling the Member Services number on the back of the ID card.

QualCare thoroughly reviews and tracks all member complaints whether made directly to QualCare, or if delegated for exploration by the member’s insurance Carrier. This is an important process from which we gain valuable information. The information is utilized to educate our staff, improve our network, and improve our educational materials and our internal procedures.

If we receive a member complaint concerning a provider, QualCare will contact the provider for his/her review and response. Each member will receive a response to their concern. For more information concerning appeals, see the provider appeals section.

Member Rights and Responsibilities
As a member of QualCare, Inc. (including Health Republic Insurance of New Jersey plan participants), we believe you have certain basic rights regarding your health care. We believe, as a patient, you also have some basic responsibilities.

You have certain Rights and Responsibilities, including:

1. A right to receive quality health care services.
2. A right to receive information about QualCare, Inc., its services, its practitioners and providers, and member’s rights and responsibilities.
3. A responsibility to supply information (to the extent possible) that QualCare and its providers need in order to provide care, including identifying yourself appropriately and using your plan ID card.
4. A right to be treated with respect and recognition of your dignity and right to privacy. You also have the right to the privacy of your medical and financial records we receive unless you allow their release.
5. A responsibility to understand your health problems and participate in developing mutually agreed-upon goals with your providers.
6. A right to candid discussions of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
7. A right to participate with your providers in decision making regarding your health care.
8. A responsibility to follow plans and instructions for care that you have mutually agreed to with our providers.
9. A right to information about preventive health services including self-care and how to stay healthy.
10. A right to voice complaints or appeals about QualCare and/or the care provided to you.
11. A right to make recommendations regarding QualCare’s Member Rights and Responsibilities policy.

Physician Services/Plan Providers Section

Changes in Provider Practice
Please contact QualCare’s Provider Relations Department in writing if any of the following information changes:

- Name
- Address or Telephone Number
- State License
- Physicians in the Group
- Office Hours
- Panel Closing
- Tax ID Number
- Covering Physician Arrangements
- Staff Personnel
- Billing Address
- Reduction in Services

Written notice should be sent to:
QualCare, Inc.
30 Knightsbridge Road
Piscataway, New Jersey 08854
Attn: Provider Relations
Emailed notices should be sent to: qcprovrel@qualcareinc.com

Facsimile notices should be transmitted to:
Fax: 732 562-7868
Attn: (Enter your County’s Name in which the changes are occurring.)
Primary Care Physicians (PCPs)

Role of the PCP:
The Primary Care Physician (PCP) is the provider responsible for managing the health care of his/her assigned members. QualCare PCPs are reimbursed through a fee-for-service model regardless of benefit plan design.

PCPs include Family Practitioners, Internists, and Pediatricians. In some cases Obstetricians/Gynecologists (OB/GYN) can be assigned as PCP (members enrolled in plan can obtain OB/GYN services without obtaining prior authorization/referral). When a PCP determines that care should be rendered by a specialty provider or other provider of service, the PCP will assist the member with coordinating services.

For HMO/POS Networks, members are required to choose a PCP at the time of enrollment. For PPO and Open Access plans, a PCP is not required, but members are encouraged to establish a relationship and seek regular care from a PCP.

Members are required to contact QualCare to change their PCP.

Status Change:
PCPs who wish to change their status with regard to accepting patients may do so with written notification to QualCare Provider Relations Department (see Changes in Provider Practice). Written notification must also be sent when a provider moves, adds a new location or leaves a practice.

Availability:
It is the PCP’s responsibility to have in place effective procedures to provide for the availability and accessibility of medically necessary care 24 hours a day, 7 days a week.

Responsibilities:
• Establish member eligibility and benefit coverage.
• Ensure that requested hospitals and referral physicians are participating providers.
• Evaluate medical necessity, proposed place of treatment and treatment plan.
• Review and confirm the specialist treatment plan.
• When necessary and appropriate, coordinate transfer of members both into and within the network of participating providers and hospitals.
• Provide Information to and cooperate with QualCare or Carrier to facilitate coverage decisions.
• Cooperate with any UM/QA Policy and Procedure administered by QualCare or Carrier.

Referrals to Non-Participating Health Care Professionals including Ambulatory Surgical Centers and Free Standing Laboratories:

Patients with QualCare coverage generally expect that when they choose to seek care from a health care professional who participates with QualCare, the entire episode of care will be reimbursed using in network benefits. For this to occur, the patient needs to be referred to QualCare participating health care professionals including other practitioners, laboratories and facilities. When a patient is referred to non-participating health care professional, the patient may incur unexpected financial liability.

Patients with QualCare coverage who have out-of-network benefits are free to choose to use these benefits for covered medical services. In doing so, the patients will generally incur higher
out of pocket costs. To ensure that patients are making informed choices regarding whether to seek care from participating or non-participating health care professionals, they must have full disclosure regarding the financial effect of such referrals under their benefit plans, including the referring physician’s financial interests, if any.

Changing a Primary Care Physician:
If a member should decide to change his/her PCP, he/she may do so immediately and at any time of the year.

PCP Request to Transfer a Member:
Physicians who are having difficulty establishing a satisfactory relationship with a patient who is a member should document problems in the patient record. In the event the Provider concludes that he/she is unable to provide Covered Services for any member, PCP may make a written request to QualCare Medical Director stating the specific problem and requesting that the Member be transferred. Reasons for transfer request must meet validity guidelines as noted in the Physician Agreement.

QualCare will first attempt to mediate the situation and final decision regarding the patient transfer is QualCare’s. Physician agrees, via the Physician Agreement, that the Member’s needs and preferences shall be given significant weight in the consideration of the transfer request. The PCP must continue to provide care until he/she is notified that the member has selected a new PCP.

QualCare Provider ID Number:
Each Primary Care Physician (PCP) is assigned a unique provider ID number that can be found in the QualCare Network Provider Directory or by calling your Provider Relations Representative. Your provider ID number will be different from your individual tax ID number. Please use your QualCare provider ID when submitting claims, or when calling QualCare.

Specialists

Role of the Specialist:
The specialists should provide medical services to members. Specialists must have a referral from the member’s PCP when the member has HMO model or POS coverage, except when member obtains gynecological and/or obstetrical services (no prior authorization or referral is required). The specialist and PCP should work together to coordinate the best care for the member. The behavioral health provider is an example of a specialist that may be consulted with to manage behavioral health care and treatment of the patient.

Status Change:
Written notification must be sent to QualCare when a provider moves, adds a new location or leaves practice, adds or reduces services, changes tax identification or contact information. (see Changes in Provider Practice)

Responsibilities:
The specialist is responsible for the following:

• Verify that prior authorization has been obtained before rendering services, if required. (Services rendered without prior authorization, when required, may result in denied claims. The member may not be billed.)
• The specialist should always verify member’s eligibility before rendering services.
• Specialists should not refer to other specialists. Members must be referred back to their PCP for
HMO model and POS plans, except where designated PCP is an Obstetrician/Gynecologist.
• The specialist must always provide a designated PCP with follow-up information when a PCP is identified.

**Referrals to Non-Participating Health Care Professionals including Ambulatory Surgical Centers and Free Standing Laboratories:**

Patients with QualCare coverage generally expect that when they choose to seek care from a health care professional who participates with QualCare, the entire episode of care will be reimbursed using in network benefits. For this to occur, the patient needs to be referred to QualCare participating health care professionals including other practitioners, laboratories and facilities. When a patient is referred to non-participating health care professional, the patient may incur unexpected financial liability.

Patients with QualCare coverage who have out-of-network benefits are free to choose to use these benefits for covered medical services. In doing so, the patients will generally incur higher out of pocket costs. To ensure that patients are making informed choices regarding whether to seek care from participating or non-participating health care professionals, they must have full disclosure regarding the financial effect of such referrals under their benefit plans, including the referring physician’s financial interests, if any.

**Advance Directives: Physicians in HMO Network**

Physicians who participate in QualCare’s HMO Network are required to provide information on advance directives to their patients.

Advance directives help physicians to identify someone authorized by the patient to make decisions in a crisis situation on the patient’s behalf. An advance directive also may allow healthcare professionals and family members to make decisions for treatment based on the patient’s stated wishes when the patient is no longer able to do so.

If any patient would like a Health Care Proxy form, which is a form of advance directive, forms are available from a number of sources, including certain social service agencies, and the New Jersey Department of Health and Senior Services.

To obtain a Health Care Proxy form from the Department of Health and Senior Services, send a written request to:

Health Care Proxy  
State of New Jersey  
Department of Health and Senior Services  
CN 367  
Trenton, New Jersey 08625

**Provider Availability Standards:**
QualCare is committed to providing high quality health care to all members, promoting healthier lifestyles and providing timely access of care. Our participating providers have agreed to meet the following Provider Availability and Access Standards.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>ACCESS STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency (See Glossary)</td>
<td>Immediate access, 24 hours a day, 365 days a year</td>
</tr>
<tr>
<td>Urgent</td>
<td>24 hours or less</td>
</tr>
<tr>
<td>Routine Care</td>
<td>2 weeks or less</td>
</tr>
<tr>
<td>Preventive Physical Exams</td>
<td>4 months or less</td>
</tr>
</tbody>
</table>

Network providers are responsible for assuring coverage 24 hours a day, 365 days a year. If a provider enters a coverage arrangement with another provider at any time, the participating provider has an obligation to ensure the covering provider abides by all terms and conditions or their participation agreement, including acceptance of QualCare’s agreed upon fee schedule, as payment in full.

**Claims and Billing Information**

1. **Provider Reimbursement**

   **Primary Care Physicians (PCPs)**
   PCPs are reimbursed on a fee for service basis and paid according to the fee schedule defined in the QualCare Provider Agreement.

   **Specialist Physicians**
   Specialists are reimbursed on a fee-for-service basis and paid according to the fee schedule defined in the QualCare Provider Agreement.

   **Please note: each physician who contracts with QualCare for the provision of services to Eligible Persons agrees to accept the fee reimbursement provided in the contract as full payment for services provided to Eligible Persons, less any applicable co-payments, coinsurance or deductible amounts.**

**Co-payments**

A co-payment is a specific dollar amount paid by the patient for a specific health service such as an office visit, outpatient prescription or emergency room visit. The required co-payment amount will be indicated on the member’s identification card. You may contact the number form Member Services Department on the ID card to verify co-payment amounts.

It is the responsibility of the physician’s office to collect the co-payment at the time of service. Any co-payment collected should be reflected on the claim form submitted.

**Billing the Patient**

For covered services, the physician may not bill members for the balance generated by the difference between actual charges and the payment received since payment reflects agreed upon rates. Claims payment constitutes payment in full for the covered services rendered to members except for co-payments, coinsurance and deductibles.

The provider is responsible for collecting from the member any co-payments, deductible or coinsurance amounts. The provider may also bill the member directly for any type of services that are not covered under the patient’s health benefit plan, provided that provider has informed
the member prior to rendering the service that the service is not covered and that the member will be responsible for payment and the member nonetheless requests that the service be rendered and provides written consent thereto.

The physician may not bill members for services which are determined through utilization management not to be medically necessary unless the physician obtains the member’s prior written informed consent as set forth above. The member’s consent will not be considered informed unless it was explained to the member prior to services being rendered that the member would be financially responsible for the services.

If you have any questions about patient billing, please call the Provider Relations Department at 1 800 992-6613.

2. Claims Submission and Payment

The preferred method of submitting claims is electronically. EDI submitted claims result in faster turnaround time than paper submitted claims. The correct NEIC Payor IDs can be found on the back of the member’s ID card. The correct Payor IDs are:

- QualCare: 23342
- Oscar Health: OSCAR
- Emblem Health: 13551

If you choose to submit a paper claim, you must complete a CMS 1500 billing form or its equivalent in its entirety. Please note any co-payments as an amount paid. Use a separate form for each member. Please have the member sign the claim form assigning benefits to the provider. You will be reimbursed according to your fee schedule for any covered services as described earlier in this Manual. Encounter information must be submitted for all visits, including visits where no billable services are provided. Encounter data must be submitted within 90 days of the date of service.

For Specialists, when applicable, please attach a copy of the referral form to the first claim submitted for a member. Referrals are valid for up to three visits.

Office Visit vs. Consultation
According to the current official American Medical Association’s CPT book, a consultation is defined as:

“A type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.”

The request for consultation must be documented in the patient’s medical record. The consultant’s opinion must be communicated to the requesting physician. When you see a patient for consultation (as defined above), the CPT 99241-99245 series should be used. Please attach the referral form to the bill.

Routine Exam/Preventative Care
To report routine care, please use the following codes:
• New Patient: Preventative CPT codes 99381-99387.
• Established Patient: Preventative CPT codes 99391-99397

Please remember to use the appropriate V codes for diagnosis (ICD-9) when billing for routine care:
• Children V20.2
• Adults V70.0
• Routine Gyn Exam V72.3

Annual Gynecological Exam and PAP
Use the appropriate preventative medicine codes (99384-99387, 99394-99397) for annual gynecological exams with PAP smears. Do not bill for the PAP separately using the Pathology code series 88XXX or Q0091. The cost of obtaining the PAP specimen is inclusive in the office visit procedure and should not be billed separately.

Newborn Care
Use CPT code(s) 99431, 99433 and 99435, as appropriate for newborn care.

Referrals (HMO/POS)
For coverage under the health benefit plans served by the QualCare HMO/POS Network, services must be provided, arranged or authorized by the member’s PCP. The PCP or office staff should complete the Referral Form when referring to in-network providers for consultations or treatment. Referrals are not required for the Open Access HMO/POS product.

This form provides the specialist with authorization to render services within the scope requested by the PCP. It also provides the specialist with an initial diagnosis and definition of the problem.

As the referral information is maintained in QualCare’s computer system, referral patterns can be identified and monitored. Among the services that require a referral form are:

1. Visits to Specialist Providers (In-Network) for HMO/POS.
2. Third or subsequent visit to an Ob/GYN in a calendar year.
3. Diagnostic Radiology.
4. Outpatient Mental Health and Substance Abuse Services

Services That Do Not Require a Referral Form or Pre-Certification
The following are services that do not require a referral form:

1. Laboratory services: Must supply laboratory with a fully completed requisition form, including member’s name, ID, health benefit plan, employer name, and group number.
2. OB/GYN: Enrolled members can access Obstetrical/Gynecological services without obtaining prior-authorization and/or referral.
HMO/POS, Open Access and PPO Services Do Not Require a Referral Form but Do Require Prior Authorization or Pre-Certification. For More information on Precertification, see Utilization Management.

1. All Elective Inpatient Hospitalizations (non-emergency)
2. Same Day Surgery
3. Skilled Nursing Facility
4. Acute Rehabilitation
5. Inpatient Mental Health (non-emergency)
6. Inpatient Substance Abuse
7. Home Health Care
8. Home Infusion Therapy
9. Durable Medical Equipment
10. Radiation Therapy
11. MRI, PET Scans
12. Physical, Occupational and Speech Therapies
13. Obstetrical Ultrasounds greater than one
14. Referrals requesting more than three visits in 90 days

For further information or clarification please reference the back of the member’s ID card or call QualCare’s Utilization Management Department at 1-800-254-0130 for HMO/POS, or 1-800-992-6613 for PPO.

Referral Guidelines
The following are general guidelines for referrals:

1. Each referral is valid for 90 days.
2. The referral period begins on the date of issuance, not the appointment date.
3. Up to three visits within 90 days are permitted for each referral. A new referral is required for additional visits.
4. Written referrals alone will not cover services that require Pre-Certification.
5. Referrals are not required for women’s wellness exams.
6. PCPs should inform the specialists in the Treatment-to-Date section of the form about any lab or diagnostics recently performed, in order to prevent duplication of tests.
7. Specialists may admit a member to the hospital. Pre-Certification guidelines must be followed.

8. Specialists may send a member to a participating diagnostic facility by using a referral form.

9. If a specialist believes a referral to another provider is required, he/she should follow up with the PCP so a referral can be written.

10. Physicians who practice primary care and a specialty may not self-refer. Such a physician will need to choose how he/she wishes to participate in QualCare’s Network.

**Referral Form and Referral Process**

- To initiate the process, the PCP and OB/GYNs need to complete the referral forms via NavinNet (https://navinet.navimedix.com). The QualCare Provider Directory and NaviNet will identify appropriate network specialists. Referrals are valid for 90 days and required for all physician specialist services.

**Referrals to Non-Participating Health Care Professionals including Ambulatory Surgical Centers and Free Standing Laboratories:**

Patients with QualCare coverage generally expect that when they choose to seek care from a health care professional who participates with QualCare, the entire episode of care will be reimbursed using in network benefits. For this to occur, the patient needs to be referred to QualCare participating health care professionals including other practitioners, laboratories and facilities. When a patient is referred to non-participating health care professional, the patient may incur unexpected financial liability.

Patients with QualCare coverage who have out-of-network benefits are free to choose to use these benefits for covered medical services. In doing so, the patients will generally incur higher out of pocket costs. To ensure that patients are making informed choices regarding whether to seek care from participating or non-participating health care professionals, they must have full disclosure regarding the financial effect of such referrals under their benefit plans, including the referring physician’s financial interests, if any.

**Submitting the Claim**

In order for the claim form to be considered complete and processed as quickly as possible, the following information must be provided. When a claim does not contain all necessary billing information, it will be returned with a request for appropriate information.

**Member Information:**

1. Name, member ID number from ID card, date of birth, sex, address.

2. Health Benefit Plan, employer identification number, group name and number, if indicated.

3. Information on other insurance or coverage. Also include copy of primary payor’s Explanation of Benefits (EOB), if applicable.
4. If care is provided as a result of an accident, indicate location, date and type of accident.

**Physician or Supplier Information:**

1. The name of the provider who referred the patient, if applicable.

2. Diagnostic code and brief description. If ICD-9 is not available, give detailed description of service/procedure performed.

3. Dates of service.

4. Place of service.

5. CPT-4 procedure codes, along with modifiers, when appropriate. If CPT-4 procedure code is not available, use appropriate coding and give detailed description of service/procedure performed.

6. Provider’s usual and customary charge for each procedure listed, along with total charges for the claim. Also include any co-payments received.

7. If billing for anesthesiology or other time-related services, specify the amount of time for the service.

8. The tax identification number or social security number of provider performing the services.

9. The provider’s NPI number of provider performing the services.

10. Name, signature and address of provider performing services.

11. For HMO and applicable POS members, a referral form must be attached for specialist visits.

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**Submitting Claims**

Please reference the address on the back of the Member’s card for to determine where that member’s claims should be sent, transmitted or faxed. Note that this information may vary from patient to patient therefore it is critical for timely and accurate claims processing that the provider reference a members ID card.

You also may call the following numbers to get this information:

PPO 1-800-992-6613
HMO/POS 1-800-254-0130
Time Limit for Submission of Claims
Provider must submit an accurate and complete claim statement within 180 days of the date of service/discharge. Failure to bill for services within 180 days of the date of services/discharge will result in forfeiture of all rights to bill the payor or the member for such services.

In the event provider is unable to submit a claim within 180 days because of circumstances beyond provider’s control, the time for submission of such bill may be extended as reasonably necessary as determined by the Member Services Department. Claims that are affected by coordination of benefit activity would be extended as appropriate, up to one year.

Claims Payment
Under circumstances which require coordination of benefits or a claims review process, claims payment may be delayed until all necessary information is received. In such cases where claims payment is delayed, the member/Provider will be provided written notice of such delay as a result of further claim review.

Explanation of Benefits
When a claim is filed and processed, a Payment Voucher will be forwarded to the participating provider. A Check may or may not be attached depending on the disposition of the claim(s). The Payment Voucher will provide a detailed description of how the benefits were paid. Any disallowances or denials will be indicated and explained on the Voucher. Questions regarding payment or more specific information related to denials or disallowances should be directed to the number on the Voucher, or the Member Services number listed on the member’s ID card. For additional assistance, you may always call QualCare’s Provider Relations Department at: 1-800-992-6613.

Claims Review Procedure
In cases where a claim for benefit payment has been denied in whole or in part, the provider may dispute the denial. See Section titled “Provider Disputes/Complaints” for information on how to file a dispute or complaint.

Ancillary Services
The following ancillary services are subject to the following guidelines unless specified:

1. Laboratory Services
   Lab work is covered as part of an office visit. If lab work is the only purpose of a member’s visit, and the member is not being seen for an office visit, a co-payment should not be collected, nor an office visit billed.

   Specimens may be drawn/collected in the office and sent to a participating lab for testing, or the member can be referred directly to a participating lab’s draw station. If the member is referred to a draw station, a lab slip must be written containing complete insurance information, including health benefit plan, employer, plan group number and member ID #.

   QualCare maintains a listing of lab tests which can be provided in a physician’s office. Lab tests not listed will not be reimbursed by the plan and a member cannot be balanced billed for this service.
NOTE: For the HMO Network, any lab work performed or requested by a non-participating physician or lab is considered a non-covered expense.

QualCare’s exclusive laboratory is Quest Diagnostics.  1-800-225-7483

Please utilize the toll free number for supplies or any information you require, including the nearest draw station.

**Billable Lab Services**
Physician’s offices with appropriate CLIA approval may perform and bill the following lab services in their offices:

**Lab Work Allowed in Physician Office:**

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>80198</td>
<td>Theophylline</td>
</tr>
<tr>
<td>80300</td>
<td>Drug screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures, (eg, immunoassay) capable of being read by direct optical observation, including instrumented-assisted when performed (eg, dipsticks, cups, cards, cartridges), per date of service</td>
</tr>
<tr>
<td>81000</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy</td>
</tr>
<tr>
<td>81007</td>
<td>Bacteriuria screen, except by culture or dipstick</td>
</tr>
<tr>
<td>81015</td>
<td>Microscopic only</td>
</tr>
<tr>
<td>81025</td>
<td>Urine Pregnancy test, by visual color comparison methods</td>
</tr>
<tr>
<td>20108</td>
<td>Acetone or other ketone bodies, serum; quantitative</td>
</tr>
<tr>
<td>82044</td>
<td>Albumin; urine, microalbumin, semiquantitative (e.g., reagent strip assay)</td>
</tr>
<tr>
<td>82120</td>
<td>Amines, vaginal fluid qualitative</td>
</tr>
<tr>
<td>82270</td>
<td>Blood; Occult, Feces Screening, 1-3 simultaneous determinations</td>
</tr>
<tr>
<td>82272</td>
<td>Blood, occult, by peroxidase activity (eg, guaiac)</td>
</tr>
<tr>
<td>82273</td>
<td>Other sources</td>
</tr>
<tr>
<td>82274</td>
<td>Fecal blood occult</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>82550</td>
<td>Creatine kinase (CK), (CPK); total</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose; Blood, Reagent Strip</td>
</tr>
<tr>
<td>83026</td>
<td>Hemoglobin; by copper sulfate method, non-automated</td>
</tr>
<tr>
<td>83986</td>
<td>PH, body fluid, except blood – vaginal rare</td>
</tr>
<tr>
<td>85007</td>
<td>Blood CT manual, differential WBC count</td>
</tr>
<tr>
<td>85014</td>
<td>Blood count; other than spun hematocrit</td>
</tr>
<tr>
<td>85015</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>85018</td>
<td>Hemogram &amp; platelet count, automated &amp; automated complete differential WBC count (CBC)</td>
</tr>
<tr>
<td>85027</td>
<td>Blood Count Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)</td>
</tr>
<tr>
<td>85031</td>
<td>Prothrombin time</td>
</tr>
<tr>
<td>85051</td>
<td>Sedimentation rate, erythrocyte; non-automated</td>
</tr>
<tr>
<td>86318</td>
<td>Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (e.g., reagent strip)</td>
</tr>
<tr>
<td>86485</td>
<td>Skin test; candida</td>
</tr>
<tr>
<td>86580</td>
<td>Tuberculosis, intradermal</td>
</tr>
<tr>
<td>86585</td>
<td>Tuberculosis, tine test</td>
</tr>
<tr>
<td>87081</td>
<td>Culture, presumptive, pathogenic organisms, screening only</td>
</tr>
<tr>
<td>87086</td>
<td>Culture, bacterial; quantitative colony count, urine</td>
</tr>
<tr>
<td>87164</td>
<td>Dark field examination, any source (e.g., penile, vaginal, oral skin); includes specimen collection – rare</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>87172</td>
<td>Pinworm exam (e.g., cellophane tape prep)</td>
</tr>
<tr>
<td>87205</td>
<td>Smear, primary source w/interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types</td>
</tr>
<tr>
<td>87210</td>
<td>Wet mount for infectious agents (e.g., saline, India ink, KOH preps)</td>
</tr>
<tr>
<td>87220</td>
<td>Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or extoparasite ova or mites (e.g., scabies)</td>
</tr>
<tr>
<td>87275</td>
<td>Influenza B virus</td>
</tr>
<tr>
<td>87276</td>
<td>Influenza A virus</td>
</tr>
<tr>
<td>87400</td>
<td>Influenza A or B, each</td>
</tr>
<tr>
<td>87430</td>
<td>Streptococcus, group A</td>
</tr>
<tr>
<td>87804</td>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; influenza</td>
</tr>
<tr>
<td>87880</td>
<td>Streptococcus, group A</td>
</tr>
<tr>
<td>89050</td>
<td>Cell count, miscellaneous body fluids (e.g., cerebrospinal fluid, joint fluid, except blood;</td>
</tr>
<tr>
<td>89051</td>
<td>With differential count</td>
</tr>
<tr>
<td>89060</td>
<td>Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)</td>
</tr>
<tr>
<td>89190</td>
<td>Nasal smear for eosinophils</td>
</tr>
<tr>
<td>89300</td>
<td>Semen analysis; presence and/or motility of sperm including Huhner test (post coital)</td>
</tr>
<tr>
<td>G0107</td>
<td>Colorectal cancer screening; fecal - occult blood test, 1-3 simultaneous determinations</td>
</tr>
</tbody>
</table>

*Note that specialists may be privileged to perform additional laboratory testing specific to their area of practice. Please contact your Provider Relations Representative at 1-800-254-0130 if you have any questions.*

2. **Radiology**

Physicians may refer members directly to any participating diagnostic imaging facility. Primary Care Physicians and specialists should issue a referral form when required.

Please note that Radiation Therapy, MRIs, MRAs and PET Scans may require precertification by QualCare’s and some Carrier’s Utilization Management Departments. Please call 1-800-254-0130 HMO/POS or 1-800-992-6613 for PPO for plans where QualCare directs the UM. For Carrier UM department, call the number on the member’s ID card.

For a complete listing of participating providers, please see the Provider Directory at www.qualcareinc.com or call Provider Relations at 1-800-254-0130 Option 6, extension 7830 for HMO/POS or 1 800 992-6613 Option 6, extension 7830 for PPO.
3. **Mental Health and Substance Abuse**
Primary Care Physicians (PCPs) can write a referral for outpatient mental health to an appropriate specialist as found in the Provider Directory. Inpatient services must be pre-authorized. The behavioral health provider can be consulted with to manage behavioral health care and treatment of the patient.

4. **Prescription Benefits**
Members may have prescription benefits as a rider to their coverage provided under their health benefit plan. In that case, members with the prescription benefits will have a separate ID card from a **Prescription Benefit Management (PBM) Plan**. Providers are encouraged to prescribe generic drugs whenever possible, in order to maximize the member’s benefit.

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**HIPAA Overview of the Administrative Simplification Regulations**

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. HIPAA is a federal law that covers health plans, providers and clearing houses. The Center for Medicaid and Medicare Services (CMS) formally known as the Health Care Finance Administration is responsible for implementing various unrelated provisions of HIPAA.

One provision of HIPAA that impacts healthcare organizations is the Administrative Simplification Act. The Administrative Simplification provisions are intended to reduce the costs and administrative burdens of health care by making possible standardized, electronic transmission of many administrative and financial transactions that are currently carried out manually on paper. Also, included in the administrative simplification section, is the establishment of standards for the privacy of individually identifiable health information.\(^1\)

**Transactions and Code Sets Overview**

As of October 16, 2003, entities covered by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 are required to process electronic transactions in formats compliant with HIPAA. CMS has taken proactive steps to help covered entities achieve compliance and to communicate key concepts and requirements contained in HIPAA. The final rule published in February of 2003 made some important changes to the HIPAA electronic transactions and code sets standards that were originally published in August 2000. These changes are detailed in documents called “addenda.”

The original implementation guides were known as version 4010, the subsequent addenda are referred to as version 4010A. The addenda also adopt modified standards for two transactions that were not included in the proposed modifications rule – Premium Payments and Coordination of Benefits.

HIPAA defines a “transaction” as the “exchange of information between two parties to carry out financial or administrative activities related to health care.”

The following are the required standard transactions:

\(^1\) 45 C.F.R. § 160.103
1. Claims or equivalent encounter information
2. Payment and remittance advice
3. Claim status and inquiry response
4. Eligibility inquiry and response
5. Referral certification and authorization inquiry and response
6. Enrollment and dis-enrollment in a health plan
7. Health plan premium payments
8. Coordination of benefits

Electronic Data Interchange (EDI) can eliminate the inefficiencies of handling paper documents. It reduces administrative burden, lowers operating costs and improves overall data quality. For further detailed information about HIPAA, log onto the CMS HIPAA web-site at http://www.cms.hhs.gov.

Privacy Overview

The Privacy Rule became effective on April 14, 2003. Most health plans and health care providers that are covered by the new rule must comply with the new requirements by April 2003. Compliance with HIPAA’s privacy regulations requires the addition of, or change to, numerous administrative processes at a health care organization. Under HIPAA, all covered entities must designate a privacy officer, create policies and procedures for handling protected health information, train employees, and sanction employees and business partners for non-compliance. The design and implementation of your plan should be reasonably developed based on the size of your organization and complexity for complying with the privacy regulations of HIPAA.

Security Overview

The security standards work in concert with the final privacy standards adopted by HHS last year. The two sets of standards use many of the same terms and definitions in order to make it easier for covered entities to comply. The final security standards for HIPAA were published on February 20, 2003. Under this rule, health plans, Payors, clearinghouses, and certain health care providers must establish procedures and mechanisms to protect the confidentiality, and integrity and availability of electronic Protected Health Information (PHI). Most covered entities were required to comply with the standards April 21, 2005.

Unique identifiers requirements

HIPAA also requires the use of unique identifiers to clearly identify entities within the health care delivery system. The final National Employer Identifier Rule compliance date was July 30, 2004. The National Employer ID will use the Internal Revenue Service’s Employer Identification Number (EIN) for this number.

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2 Source: CMS HIPAA Information Series
Medical Record Guidelines

Medical Records Policy
QualCare Network providers are required to maintain a centralized medical record for each member. The individual record includes care provided within and referred outside the Network.

QualCare Network providers are required to maintain policies and procedures which address release of patient information to any internal and external person. Each office must have a copy of the policy.

The member medical record must be maintained in a current, detailed, organized manner that permits effective patient care and facilitates quality review.

The medical record is a legal document and its contents are confidential.

Policy Objective
To ensure that the care rendered to members is consistently documented and that the documentation is of high quality, with all information necessary to make medical determinations readily available at all times.

To ensure that the medical record is complete and that it includes all of the elements of the member’s health history, treatment rendered, and response to treatment.

To ensure the same and effective transfer of care between the Primary Care Provider and the specialty provider in the interest of excellence in member care and to enhance service between providers.

To ensure the protection of confidentiality of patient medical records maintained at the physician’s practice site.

Scope
Guidelines should be applied to the medical records of all members.

Standards
Our standards for medical records include organization, documentation and completeness. Please see below for an explanation of each:

1. Organization

The record is to be organized as follows:

a. Each member’s medical record must be individually trackable.

b. The record is secured to maintain confidentiality.

c. There is a section for patient identification which includes name, age, gender, employer, occupation, work and home telephone number, insurance information and marital status.

d. Every page in the record should contain the member name or ID number.

e. All entries contain author identification, are legible, and dated.
2. **Documentation**

The following information is to be documented:

a. Medication allergies and adverse reactions are noted in a consistent, prominent place.

b. Past medical history (including use of cigarettes, alcohol and substance abuse) is documented in the record of members who have been seen two or more times.

c. Problem lists are used for members with significant illnesses and/or conditions which should be monitored. A chief complaint and diagnosis or probable diagnosis is included.

d. There is documentation of an exam appropriate for the condition.

e. All medications prescribed are noted, listing name, dosage, frequency and duration.

f. Medications given on-site are noted, listing name, dosage, route, as well as the site given and batch number of drugs.

g. Treatments, procedures, tests and results are documented.

h. Member education, recommendation and instructions given are included.

i. Member records have a completed immunization record or notation of immunizations up to date.

3. **Completeness**

The following is done in a timely manner:

a. The medical record is checked to assure that all ordered procedures and referrals are returned and filed in the chart in a timely fashion commensurate with referral or procedure.

b. The provider reviews and initials all test results and consultations within seven working days or more quickly, as may be appropriate to the circumstances.

**Medical Record Review**

1. Medical record review to determine compliance with standards is conducted by the Quality Management Committee.

2. Findings of review are reported to the Board of Directors of QualCare, and include conclusions, recommendations and follow-up.

3. Opportunities to improve care/service are included in the provider’s Quality Profile for use at the time of recredentialing.

4. Providers are given information regarding medical record guidelines and standards at the time of appointment to the Provider Panel, and at the time of any medical record guideline revision.
PROVIDER DISPUTES/COMPLAINTS

ISSUE TYPES:

**Administrative Claim Disputes** relate to all decisions made during the claims adjudication process.

**Utilization Review Issues** relate to decisions made during the precertification, concurrent or retrospective review processes. See Section titled “Utilization Management Appeal Process” for information on how to file.

**Other Provider Complaints** may include but not be limited to such other issues as network sufficiency and access to other providers, confirmation of provider participation, QualCare provider policies and procedures, responsiveness of QualCare staff, reimbursement fees, etc.

**Administrative Claim Dispute Procedure**

A provider may file a claim dispute verbally by contacting the Customer Service telephone number on the member’s Identification card.

If the provider wishes to submit additional information related to the claim dispute, the provider may submit the request for review in writing, stating in clear and concise terms as to the reason for the dispute. The written request must include the following information:

- Name of the Subscriber
- Name of the Patient
- Patient’s Identification Number
- Patient’s Group Number
- Claim Number of the claim in dispute
- Additional information relating to the dispute, including the reason for the dispute.
- It is helpful to also submit a copy of the provider voucher reflecting the original payment or denial.

All claim disputes, whether verbal or in writing, must be initiated within 90 days after the date the provider receives notification of payment or denial. Requests for review if initiated after 180 days of notification of payment or denial may not be considered eligible for consideration.

Written requests for review of claim dispute should be addressed as follows:

QualCare  
Claim Review Department  
PO Box 249  
Piscataway, NJ 08854

Upon receipt of the request for review, QualCare will review the claim for resolution of the dispute within 60 days. If the dispute is determined to be valid, the claim will be reprocessed accordingly and the provider will receive notice via the Provider Voucher. If the original claim adjudication decision is upheld, the provider will be advised of the decision verbally if the dispute was initiated verbally or in writing if the dispute was submitted in writing. If QualCare
requires additional time to review the dispute, QualCare will notify the provider within that 60-day period. QualCare will provide final resolution response no later than 60 days of such notification.

Other Provider Complaints Procedure

Providers may register other types of complaints by contacting the Provider Relations Department by phone, or in writing via mail, email, or fax, as follows:

Phone #: - 1.800.992.6613, Option #6, Extension 7830

Fax #: - 732.562.7868

Mail: - Provider Relations Department

QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854

Email: qcprovrel@qualcareinc.com

Please be prepared to provide the following information when registering a complaint:

- Provider contact information, including address, phone and fax #s.
- Your office contact person’s name and title.
- Your Tax Identification #.
- Cogent description of the complaint.
- Preferred contact times for follow up with your office.

QualCare is dedicated to resolving provider complaints with alacrity, whenever possible. Generally, such responses will be made in the same manner as they were received, by phone or in writing.

Carriers and Payors Using Vendors Other than QualCare:

Payors and Carriers who access the QualCare network may have contracted with QualCare or an alternate vendor to process claims and provide utilization management services. Providers can use the information on the member ID card to contact the appropriate vendor to obtain information as to how to file a claim dispute or complaint. For Oscar, please refer to their provider manual: https://provider.hioscar.com/resources/new-jersey/Overview/ for more information.

Additionally, providers may register complaints with QualCare which relate to service, policies and procedures of a Payor or carrier accessing the QualCare network. You may access assistance in where to file a dispute/complaint by contacting Provider Relations at: 1-800-992-6613, option 6, extension 7830. These complaints are tracked and forwarded to the carrier for resolution with the response to the provider being coordinated by QualCare.

QualCare will maintain on our website the Complaint and Appeal Process for any carriers accessing the QualCare Network.
Utilization Management Program:

Program Summary
QualCare’s Utilization Management (UM) Program is designed to ensure that covered individuals receive quality medical care in a cost effective environment.

Utilization Management can be defined as a system of pre-admission, concurrent and retrospective review of inpatient and outpatient healthcare services. The Utilization Management Program incorporates all of these reviews in an effort to control the costs of healthcare while assuring the provision of quality care in accordance with local, state and national standards. The primary components of the Utilization Management Program are:

- Hospital/Inpatient
- Pre-admission Certification
- Concurrent Review
- Prospective Review
- Retrospective Review
- MH/SA Review
- Skilled Nursing
- Disease Management
- Ambulatory/Outpatient
- Second Surgical Opinion
- Ambulatory Certification
- Medical Case Management
- Specialty Referral Authorization
- Long Term Care
- Pharmacy
- Case Management

QualCare's Utilization Management Program applies to certification of the medical necessity of services and treatment based on nationally recognized screening and length-of-stay criteria. Certification determinations are only a guide regarding medical necessity and are used by the claims administrator to determine how to pay the claim.

For carriers utilizing an alternate vendor to process claims or provide utilization management services, please refer back to the carrier for additional information.

Irrespective of any utilization management determination, the decision as to whether any medical service should be rendered remains with the member and the attending physician. Decisions regarding the provision of healthcare services are made under the following provisions:

- Utilization Management decision making is based only on appropriateness of care and service and the existence of coverage.
- QualCare does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

The nurses, physicians, other professional providers, and independent medical consultants who perform utilization review services for the Plan are not compensated or given incentives based on their coverage review decisions. There are no financial incentives for such individuals that would encourage utilization review decisions that result in underutilization.

The Utilization Management Program is designed to monitor, evaluate, and manage the resources and quality of healthcare services delivered to all members of QualCare. This Program attempts to ensure that:
Services are medically necessary and are delivered at appropriate levels of care.

Authorized care matches the benefits defined in the member’s health plan.

Covered services are provided by QualCare contracted providers unless otherwise authorized by QualCare.

Hospital admissions and length of stay are justified.

Services are not over utilized or underutilized.

Appropriate care is offered in a timely manner and is quality-oriented.

Scheduling is efficient for services and resources.

Costs of services are monitored, evaluated and determined to be appropriate.

Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as mandated.

QualCare will maintain compliance with the regulations set for the specific contracted member populations (e.g. Commercial, Medicare, Medicaid).

QualCare utilizes standard criteria and informational resources to determine the appropriateness of healthcare services to be delivered (e.g., InterQual, MCG Health).

The Utilization Management team of physicians, licensed staff, and unlicensed staff carryout the responsibilities designated for the level of expertise.

A Utilization Management Work Plan will be written and reviewed annually.

The Utilization Management Program’s plan, policies and procedures will be reviewed and approved and, if necessary, revised on at least an annual basis by the Utilization Management Committee.

The Utilization Management Program will be integrated with the Quality Management Program to ensure continuous quality improvement.

New and existing technology and treatments are evaluated within the Cigna Coverage Policy Unit.

The Utilization Management Program will be reviewed annually by the Quality Management Committee (QMC).
Physician Review and Comment of Criteria
All services authorized by the Utilization Management Staff are evaluated to determine medical necessity based on standard criteria (e.g. InterQual, MCG Health). The criteria is reviewed, revised (as appropriate) and approved on at least an annual basis by the Utilization Management Committee (UMC) followed by QualCare Quality Management Committee (QMC) review. The QMC includes participating QualCare providers.

The clinical criteria utilized for review and determinations are available upon request to all participating providers. Participating providers are welcome to submit comments concerning the criteria. To obtain copies of the criteria, submit a written request specifying your specialty and specific area of interest to:

QualCare Utilization Management Criteria
P.O. Box 820, Piscataway
New Jersey, 08855-0820
Fax: 732-562-1023

Pre-certification
Precertification is QualCare’s process of authorizing services by reviewing related documentation, verifying benefits and medical necessity and ensuring the appropriate provider will be delivering the services. Pre-certification is defined as approval from QualCare prior to the patient receiving services.

Precertification requirements may be dependent on the member’s plan description. The Pre-Certification Grid below provides general guidelines which apply to most plans accessing QualCare. When in doubt, call the Pre-Certification number indicated on the member’s ID card.

Pre-Certification Guidelines

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Referral Form Required</th>
<th>Pre-Certification Required</th>
<th>Who Should Request Pre-Authorization?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>No</td>
<td>Yes</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Same Day Surgery</td>
<td>No</td>
<td>Yes</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>No</td>
<td>Yes</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>No</td>
<td>Yes</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Hospice</td>
<td>No</td>
<td>Yes</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Mental Health, Inpatient</td>
<td>No</td>
<td>Yes</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Mental Health, Outpatient</td>
<td>No</td>
<td>No</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Substance Abuse, Inpatient Care</td>
<td>No</td>
<td>Yes</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Specialist Physicians</td>
<td>*</td>
<td>*</td>
<td>PCP</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>*</td>
<td>*</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>No</td>
<td>Yes</td>
<td>PCP/Specialist</td>
</tr>
<tr>
<td>MRI</td>
<td>No</td>
<td>Yes, for some plans</td>
<td>PCP/Specialist</td>
</tr>
</tbody>
</table>
PET Scan | No | Yes | PCP/Specialist
--- | --- | --- | ---
Laboratory | Lab Slip | No | PCP/Specialist-refer to drawing station or call lab for pick up
Maternity Services | No | No | OB/PCP
Home Health Care | No | Yes | PCP/Specialist
Durable Medical Equipment | No | Yes | PCP/Specialist
Physical, Occupational Speech, Cardiac and Cognitive Rehab | No | Yes | PCP/Specialist
Amniocentesis | No | Yes | OB/GYN
Obstetrical Ultrasounds greater than 2 | No | Yes | OB/GYN
Emergency Room Visits | No | If admitted, authorization for continued stay must be obtained | PCP/Specialist

*No for PPO; for HMO/POS Network, please refer to I.D. card.
Please call the Population Health Management (Utilization Management) Department at the number listed on the back of the member’s identification card for questions regarding Pre-Certification or at 800-992-6613 during normal business hours from 8 am – 6 pm EST.

You may also reach us at:

**P.O. Box 820**
**Piscataway, New Jersey 08855**

or via Fax at:

**(732) 562-1023**

The criteria used for UM decision making will be provided upon request.

**Hospital Pre-Certification**

The pre-certification forms on pages 45-50 can be used to begin the pre-certification process. For additional forms, check the QualCare Web site.

**Preadmission Review**

Preadmission review examines the necessity of hospital admission before actual admission to ensure that medical services are, indeed, necessary and rendered in the most cost effective environment and manner.

A request for medical services is submitted by the member or provider prior to scheduling the proposed admission. The request should include supporting documentation as to why the services are medically necessary. Required admission review determinations are best facilitated if the provider initiates the call on behalf of the patient.

Should the admission be an emergency, the certification process should be initiated within 24 hours after the admission, or the first business day after the admission, should the admission take place at night or over the weekend.
Preadmission Review – Certification Process

The attending provider calls QualCare's Utilization Management Department at the telephone number listed on the Member’s Identification Card. The following basic information on the proposed hospitalization will be requested.

**Member information required:**
- Member Name
- Address, telephone number, member ID number
- Health Benefit Plan, Employer, Group ID number, if applicable
- Date of birth
- Other health insurance coverage for coordination of benefits
- If a result of an injury, how did it occur, and does Worker’s Compensation apply
- Motor Vehicle Accident (MVA), primary of secondary coverage

**Provider information required:**
- Admitting provider’s name, phone number and provider ID number
- Name of facility
- Diagnosis/chief complaint/problem
- Date and type of procedure/surgery scheduled
- Expected date of admission
- Expected length of stay
- If the admission is the result of an accident, information regarding the accident

**Attending Provider**
If the attending provider did not initiate the pre-certification process, the attending provider will be contacted for the reason for the hospitalization, proposed treatment or surgery and the number of days anticipated.

**Nurse Coordinator (Care Manager)**
All initial determinations on the appropriateness of the proposed admission are made by the Utilization Management Nurse, using InterQual® and/or MCG Health Medical Management criteria. Should the case not meet the criteria, the case is referred to the Medical Director or designated Physician Advisor. A nurse can only render an approval determination or recommend an alternative treatment. Only a physician can determine certification for an alternative treatment plan or deny an admission certification.

The Nurse Coordinator will notify the patient, attending provider and the hospital in writing within one (1) business day whether admission can or cannot be certified as medically necessary under the terms of the benefit plan.

Any time a proposed hospitalization is not certified because the Nurse Coordinator is unable to obtain the necessary medical information from the attending provider to perform the review, letters will be sent to all parties indicating that the admission could not be certified as medically necessary based on the information available. Information on appeals procedures will be included with the letter.
Medical Director
If a request for admission does not meet InterQual® and/or MCG Health criteria for pre-certification, the Nurse Coordinator will refer the case to the Medical Director and/or Physician Advisor.

The Medical Director will review the case for appropriateness. The Medical Director may call upon a Physician Advisor to assist in such review or assign review to such Physician Advisor. If the Medical Director and/or Physician Advisor deem the admission to be appropriate, the admission is certified, a length of stay assigned and all parties are notified.

If the Medical Director and/or Physician Advisor deem the admission to not be appropriate, the Medical Director or Physician Advisor will arrange a phone consultation with the attending provider. Procedures for appealing a non-certification of services will be sent with the non-certification notification.

Surgical Admissions
Patients who are scheduled for elective surgery should be admitted to the hospital on the day of surgery. If the scheduled date of surgery is not the same date as the date of admission, the attending provider will need to provide medical justification. Payment of charges associated with an admission on the night before a surgical procedure may be denied unless specific medical justification is provided and approved.

Obstetrical Admissions
When the patient is admitted for an obstetrical delivery by the attending provider, the Precertification Department should be notified by calling the number on the back of the member’s identification card.

Concurrent Review
Concurrent review is a continuous assessment of a patient’s medical necessity for admission; appropriateness of services rendered, and continued stay at the appropriate level of care. The concurrent review consists of three major parts: Admission Review, Continued Stay Review and Discharge Planning.

Concurrent review begins within one (1) working day after a patient’s admission. The Nurse Coordinator will call to verify the admission and to obtain information about the patient’s condition and treatment. Information is obtained from the hospital’s Utilization Review Department. If the information cannot be obtained from the hospital, the attending provider’s office will be contacted.

Continued Stay Review
When the patient has been admitted to the hospital, the patient’s record will be reviewed periodically. This review will be conducted by either an on-site visit by the Nurse Coordinator or through telephone communications with the attending provider’s office or the hospital’s Utilization Review Department. The frequency of review will depend upon the patient’s condition and diagnosis.
If a patient remains in the hospital beyond the anticipated discharge date established during the preadmission certification, medical justification for each day of hospital care beyond the preadmission anticipated discharge date will be required.

If the findings do not meet the criteria, the case will be referred to the Medical Director and/or Physician Advisor for a determination. The extension for continued services will either be approved or non-certified. If the Medical Director and/or Physician Advisor do not find cause for the continued stay, the attending provider will be notified that the case is no longer certified and that discharge is encouraged. A letter will be sent within one (1) working day of receiving the determination. Procedures for appealing a denial will be sent with the denial notification.

**Discharge Planning**
Effective discharge planning is a critical component of the utilization review process. It is imperative that discharge planning begin upon admission with assessment of each patient’s potential continuing care needs.

Often patients can be released from the hospital and placed into a less costly setting, when appropriate continuing medical care has been arranged. The discharge planning program has been designed to identify potential cases that will require additional treatment or care after the certified inpatient days of stay are completed and to facilitate a smooth transition from the hospital setting.

**Ambulatory Review**
Ambulatory review is a component of the Utilization Management Program which determines the medical necessity and appropriateness of outpatient care, as well as assuring that members are provided services in a setting best suited for their medical needs and maximizing member benefits.

Use these forms for precertification of services or check the QualCare Web site under Provider Services supplies. (Need to copy and attach all the revised UM Precert forms that are on the Web Site)
Inpatient Pre-Certification Form

All Elective Procedures Must be Pre-Certified 5 Days Prior to the Date of Service
All Maternity Admissions Require Notification During the First Trimester - Use the Maternity Notification Form

Date: ______________________________ Phone Number: ______________________________

Physician’s Name: ______________________________
Admitting Physician (if different from above) Phone Number: ______________________________

Patient’s Name: ______________________________ Phone Number: ______________________________

ID Number: ______________________________ Date of Birth: ______________________________ Age: □ Male □ Female

Name of Other Group Insurance: ______________________________ ID Number: ______________________________

Diagnosis: ______________________________ ICD 9 Code: ______________________________
Other Diagnoses or Comorbidities: ______________________________
Is the diagnosis related to: □ Workers’ Compensation □ Motor Vehicle Accident

Procedure/Service: ______________________________
CPT Code: ______________________________
Treatment Prior to Admission/Surgery: ______________________________

Admission Date: ______________________________ Anticipated length of stay:
Admission Type: □ Medical □ Surgical □ Mental Health □ Rehabilitation □ Substance Abuse
Urgency Status: □ Elective □ Urgent □ Emergent

Facility: (Must be In-Network to receive In-Network Benefits)
Name of Facility: ______________________________
Address: ______________________________
City: ______________________________ State: ______________________________ Zip: ______________________________
Phone Number: ______________________________ In Network? □ Yes □ No

PCP Name (if applicable): ______________________________

Name(s) of Planned Consultant(s) or Surgical Assistant(s): (Should be participating within the QualCare Network)
1. ______________________________ 2. ______________________________

Pre-Certification Department Fax Number: 732-562-1023
PPO 800-992-6613 (Phone) HMO Network 800-254-0130 (Phone)

Check Benefits
Some Groups Do Not Provide Coverage at Non-Participating Facilities

Inpatient Pre-Certification/Version 1/Final 9/2005
Maternity Notification

All Maternity Admissions Require Notification During the First Trimester

Note: Prior Approval is required for more than three (3) ultrasounds.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Fax Number:</td>
</tr>
<tr>
<td>Physician’s Name:</td>
<td>Tax ID Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>ID Number:</th>
<th>Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>COB: Other Group Insurance:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID Number:</th>
<th>Group:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code:</th>
<th>Gravida:</th>
<th>Para:</th>
<th>EDC:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Include CPT Code:</th>
</tr>
</thead>
</table>

Anticipated Delivery Type:

- [ ] Vaginal
- [ ] C-Section
- [x] If Cesarean Section: [ ] Primary [ ] Repeat

Reason for repeat C-Section: __________________________

Hospital where delivery will take place: __________________________

Date of First Prenatal Visit: __________________________

Last Menstrual Period: __________________________

<table>
<thead>
<tr>
<th>High Risk Pregnancy?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, please specify:

- [ ] Infertility Treatment
- [ ] Multiple Pregnancy
- [ ] Advanced Maternal Age
- [ ] Labor & Delivery Complications
- [ ] Previous Preterm Labor
- [ ] Fetal Risks
- [ ] Life Style (specify): __________________________
- [ ] Medical Complications (list):
- [ ] Repeat Maternity Ultrasounds - Place of Service __________________________

PPO Fax Number: 732-562-1023
HMO Network Fax Number: 732-562-1023

Phone Number: 800-992-6613
Phone Number: 800-254-0130

QC Maternity Pracall/Revised-4/2008
Same Day Surgery Pre-Certification Form

All Elective Procedures Must be Pre-Certified 5 Days Prior to the Date of Service

All Maternity Admissions Require Notification During the First Trimester - Use the Maternity Notification Form

<table>
<thead>
<tr>
<th>Date:</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
<td>PCP Name:</td>
</tr>
<tr>
<td>Physician's Name:</td>
<td>E-mail Address:</td>
</tr>
<tr>
<td>Patient's Name:</td>
<td>Phone Number:</td>
</tr>
<tr>
<td>ID Number:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Age:</td>
<td>Gender: Male</td>
</tr>
<tr>
<td>Name of Other Group Insurance:</td>
<td>ID Number:</td>
</tr>
</tbody>
</table>

Current Diagnosis: ICD 9 Code: |

Other Diagnoses or Comorbidities: |

Additional Information Relating to Medical Necessity: |

Is the diagnosis related to: Workers' Compensation | Motor Vehicle Accident |

<table>
<thead>
<tr>
<th>Procedure:</th>
<th>CPT Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
<td></td>
</tr>
</tbody>
</table>

Facility: (Must be In-Network to receive In-Network Benefits)

- Provider's Office
- Same Day Surgery Unit
- Free-Standing Facility

Name of Facility: |

Address: |

City: | State: | Zip: | Phone Number: |

Urgency Status: Elective | Urgent | Emergent |

Prior Outpatient Treatment: |

PCP Name (if applicable): |

Admitting Physician: |

Phone Number: |

Name(s) of Planned Consultant(s) or Surgical Assistant(s): (Should be participating within the QualCare Network)

1. |
2. |

Pre-Certification Department Fax Number: 732-662-1023

PPO Phone Number: 800-992-6613 HMO Network Phone Number: 800-254-0130

Check Benefits:
Some Groups Do Not Provide Coverage at Non-Participating Facilities
Elective Surgery
Foot and Lower Leg

Member Name: ______________________ ID Number: ______________________

Date of Birth: ______________________

Other Insurance/COB: ______________________

If injury, was this a result of: □ Motor Vehicle Accident □ Workers’ Compensation

Surgeon’s Name: ______________________ Provider ID Number: ______________________

Address: ______________________

City: ______________________ State: _______ Zip: _______

Phone Number: ______________________ Fax Number: ______________________

Brief medical history, including chief complaint:

Treatment:

Duration of conservative care: ______________________

Proposed surgical procedure(s): ______________________

CPT Codes: ______________________

Proposed Anesthesia: ______________________

Treatment Place: □ Office □ Hospital □ SurgiCenter

Other than hammer toe correction, a preoperative weight bearing X-ray must be submitted for osseous surgery. For osseous surgery, a photograph of the involved foot must be submitted.

Signature: ______________________ Date: ______________________

Pre-Certification Department Fax Number: 732-562-1023

PPO 800-992-6613 (phone) HMO Network 800-254-0130 (phone)

QC Elective Surgery Foot and Lower Leg /Version 1/Final/9/2005
Diagnostic Testing Pre-Certification Form

All Elective Procedures Must be Pre-Certified 5 Days Prior to the Date of Service
All Maternity Admissions Require Notification During the First Trimester - Use the Maternity Notification Form

<table>
<thead>
<tr>
<th>Date:</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
<td>Patient's Name:</td>
</tr>
<tr>
<td>Physician's Name:</td>
<td>Phone Number:</td>
</tr>
<tr>
<td>ID Number:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Name of Other Group Insurance:</td>
<td>ID Number:</td>
</tr>
</tbody>
</table>

**Current Diagnosis:**

ICD 9 Code: ______________________

Other Diagnoses or Comorbidities:

Additional Information Relating to Medical Necessity:

Is the diagnosis related to:  
- [ ] Workers' Compensation  
- [ ] Motor Vehicle Accident

**Procedure (Indicate CPT Code):**

- [ ] Colonoscopy  
- [ ] Pulmonary Function Test  
- [ ] Sigmoidoscopy  
- [ ] EGD  
- [ ] CAT Scan  
- [ ] Bone Density  
- [ ] MRI, type, with or without contrast:
  - [ ] Office Procedure over $1,000 (HUMC Only):
  - [ ] Other: ______________________ CPT 4 Code: ______________________

**Date of Service:** ______________________

**Facility:** (Must be In-Network to receive In-Network Benefits)

- [ ] Provider's Office  
- [ ] Same Day Surgery Unit  
- [ ] Free-Standing Facility

Name of Facility: ______________________

Address: ______________________

City: ______________________ State: ________ Zip: ________ Phone Number: ______________________

**Urgency Status:**  
- [ ] Elective  
- [ ] Urgent  
- [ ] Emergent

**Prior Outpatient Treatment:** ______________________

**PCP Name (if applicable):** ______________________

Pre-Certification Department: ______________________ Fax Number: ________

PPO 800-992-6613 (Phone)  
HMO Network 800-254-0130 (Phone)

**Check Benefits:**  
Some Groups Do Not Provide Coverage at Non-Participating Facilities

QC Diagnostic Pre-Certification /Version 1/Final/9/2003
Chiropractic Pre-Certification Form

QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854-3754

Patient’s Name: __________________ ID Number: ____________ Group: ______________
Date of Birth: ______________ Age: ______ Occupation: ____________________________
Other Insurance/COB/Policy Number: _____________________________________________
Prior Chiropractic care? □ Yes □ No If yes, when: ____________________________________
Total office visits to date: _______________________________________________________

Patient Complaints:
Primary symptoms, with or without radiation:
Duration: __________________ Frequency: __________________
Quality: □ Ache □ Burning □ Numbness □ Sharp □ Dull □ Spasm
Exacerbated by: ________________________________________________________________
Relieved by: _________________________________________________________________
Other: ______________________________________________________________________

History:
Onset Date: __________ First Visit Date: ______________ Injury due to: □ MVA □ WC □ Other
Pre-existing conditions: _________________________________________________________

<table>
<thead>
<tr>
<th>Cervical Spine</th>
<th>Thoracic/Lumbar Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Measured</td>
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<tr>
<td>Flexion</td>
<td>50</td>
</tr>
<tr>
<td>Extension</td>
<td>60</td>
</tr>
<tr>
<td>Rt. Lateral Flexion</td>
<td>45</td>
</tr>
<tr>
<td>Left. Lateral Flexion</td>
<td>45</td>
</tr>
<tr>
<td>Rt. Rotation</td>
<td>80</td>
</tr>
<tr>
<td>Left Rotation</td>
<td>80</td>
</tr>
</tbody>
</table>

| George’s Test                  | Kemps       |
| Compression Test               | Lasègues    |
| Distraction                    | Braggards    |
| Biceps Reflex                  | Patella Reflex|
| Brachioradial Reflex           | Achilles Reflex|
| Triceps Reflex                 | Babinski’s Sign |
| Sensory Testing                | Sensory Testing |
| Soto Hall                      | Linders      |
| Valsalva                       | Milgrams     |
| Cranial Nerves                 | Shoulder Dep Test |

Subluxation Findings:
Trigger Points: __________________________________________________________________
Dermatomes: _______________________________________________________________________

Radiographic Findings:
Film Date: __________________ Location: __________________ View taken: __________________
Positive Findings: __________________________________________________________________
MRI/Other Diagnostic Findings: _______________________________________________________

Diagnosis: (List by ICD 9 Codes and Description)
1. ____________________________________________________________________________
2. ____________________________________________________________________________
3. ____________________________________________________________________________
4. ____________________________________________________________________________

Treatment Plan:

Visit Frequency: __________________________________________________________________
Estimated Discharge Date: __________________________________________________________
Chiropractor: ______________________ Tax ID Number: _______________________________
Phone Number: ______________________ Fax Number: _________________________________

Pre-Certification Department Fax Number: 732-562-1023
PPO 800-992-6613 (Phone) HMO Network 800-254-0130 (phone)

QC Chiropractic Pre-Certification/Version 1/Final/9/2005

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Retrospective Review
Retrospective review is the procedure for reviewing the necessity and appropriateness of medical services after care is rendered. Cases which were not reviewed on a concurrent basis, such as emergency admissions, will be retrospectively reviewed. Retrospective medical reviews may also be conducted at other times in QualCare's sole discretion. However, except in cases of fraud, services which were precertified shall not be retroactively denied for medical necessity.

Case Management Program
The admission and concurrent review process assists in identifying those cases that might benefit from comprehensive case management. As soon as a potential catastrophic illness or injury case is identified, the Care Manager will notify the applicable payor of the impending financial liability, and determine what types of alternative benefits, if any, might be available for the patient.

Early intervention helps focus on identifying medical treatment options and suggestions for alternatives. Care Managers work with the patient, family, primary care physician, payor and other health care providers to identify treatment options that best meet the patient’s needs.

Physicians may refer covered individuals to any of the Case Management programs by calling the toll-free service telephone number, 1-800-992-6613, and speaking with a representative to initiate a referral to the appropriate program. Members can also be identifies at the time of hospital discharge, through self-referral, and Members may opt of a program at any time.

Disease Management Program
As part of QualCare’s Quality Management Program, we have developed our Disease Management Program, which is designed to identify patients with complex chronic conditions, such as Diabetes, Coronary Artery Disease, or Asthma, and work collaboratively with patients and their physicians to improve health care outcomes.

The program includes:
- Support from our Care Managers and other health care staff to ensure that your patients can understand how to best manage their condition(s) and periodically evaluate their health status.
- Membership into our Educational Program
- Educational and informational materials that can assist your patients in understanding and managing the medications you prescribe.
- Important reminders for patients to help manage their condition(s)disease
- How to effectively plan for visits to see you.
- Correspondence designed to keep you informed about your patients.

Physicians may refer covered individuals to the Disease Management program by calling the toll-free service telephone number, 1-800-992-6613, and speaking with a representative to initiate a referral.

By working collaboratively with you and our members we know our patients will receive the quality care they have come to expect and deserve.
UTILIZATION MANAGEMENT DENIAL PROCESS

A consistent procedure is followed by QualCare’s utilization management staff to inform providers and members for requests for services that are denied coverage. The procedure includes notification of QualCare’s appeals process as well as the implementation of the appeal process.

Utilization Management staff will send denial letters to providers and members after the Medical Director or designated physicians have reviewed and determined the requests to be inappropriate or not medically necessary based on medical necessity criteria such as InterQual® or MCG Health, medical policy, standard of practice guidelines and/or the member’s Benefit Summary Plan Description. The UM staff will notify the provider/member of coverage denials over the telephone immediately after the determination has been made.

All denials of coverage will be handled in a timely manner, under the guidelines of the member’s Summary Plan Description for self-funded Plans, or under State Regulatory requirements for self-insured plans.

Denial letters, signed by the Medical Director or designee, are sent to members and providers by the UM staff upon denial by the Medical Director or Physician designee. These denial letters are used to communicate to the member and provider that the requests for coverage are denied. The reasons for the denials and the medical criteria used to support the denial, are explained in the letters.

Denial of services includes, but may not be limited to, the following reasons:

a) The provider is not contracted with QualCare.
b) The service is not medically necessary, as determined by QualCare’s medical director based upon nationally-accepted standards of care, medical policy or the member’s Summary Plan Description.
c) The member is not eligible.
d) The service is not a covered benefit.
e) The member’s benefits for that service have been exhausted.
f) The services can be provided by a participating provider.
g) The services can be provided at an alternate level of care.
h) The referring physician is not contracted with QualCare.
i) The service requested is not consistent with QualCare’s medical and administrative policies.
j) The provider is not capable, based upon information concerning its quality of care and service capabilities, of providing an acceptable quality of care to a Member.

For carriers utilizing an alternate vendor to process claims or provide utilization management services, please refer back to the Carrier for additional information.

UTILIZATION MANAGEMENT APPEAL PROCESS

The Appeal Process as it relates to adverse decisions made during the precertification, concurrent or retrospective review process only apply to appeals received subsequent to the services being rendered. The member appeal process applies to appeals related to pre-service or concurrent medical necessity decisions. Appeal processes differ from Self-Funded Plans under ERISA guidelines and those plans that are Self-Insured.
1. Level I - Appeal (Informal Internal Review)

QualCare maintains an informal internal appeal process (Level I Appeal) whereby any member or any provider acting on behalf of a member, with the member's consent, who is dissatisfied with any QualCare Utilization Management determination, may file an appeal with the Medical Director and/or his or her physician designee who rendered the initial determination for clinical issues being appealed.

NOTE: No provider may be terminated or penalized solely because of filing a complaint or appeal.

Level I Appeals may be verbal (over the telephone) or in writing.

Level I Appeals shall be concluded as soon as possible in accordance with medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care and five (5) business days in the case of all other appeals.

The Level I Appeal responses will include a recitation of the issue, the resolution and rationale, and, if appropriate, the process for a Level II Appeal.

The response process may be initially completed verbally. However, a written response will follow. The response will be documented in the data system of the QualCare's Utilization Management Department. If the Appeal is not resolved to the satisfaction of the member and/or provider at this level, QualCare shall provide the member and/or the provider with a written explanation of his/her right to proceed to a Level II Appeal.

2. Level II Appeal (Formal Internal Review)

QualCare maintains a formal internal Utilization Management appeal process (Level II Appeal), whereby, any member (or any provider acting on behalf of a member, with the member’s consent), and/or provider who is dissatisfied with the results of the Level I Appeal, shall have the opportunity to pursue his/her appeal before a panel of physicians and/or other health care professionals selected by QualCare who have not been involved in the Utilization Management determination at issue.

The Peer Review Committee will act as the formal Appeal panel. The Committee consists of participating QualCare Physicians. The Committee also has consultant practitioners and licensed health care professionals available to ensure that the panel consists of members who are trained, or who practice in the same specialty, as would typically manage the case at issue.

The practitioner(s) and/or health care professionals(s) involved in the initial Utilization Management determination at issue shall not participate on the this committee panel unless requested by the member and/or provider.

The member and/or provider must submit a request and any additional information available for a Level II Appeal review in writing within sixty (60) business days of the determination of the Level I Appeal.
All Level II Appeals shall be acknowledged by QualCare, in writing, to the member and/or provider filing the appeal within ten business days of receipt.

Level II Appeals shall be concluded as soon as possible after receipt by QualCare in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care and twenty (20) business days in the case of all other appeals.

Extension requests up to an additional (20) twenty business days may be granted for delay which is beyond QualCare’s control.

The member and/or provider, as applicable, shall receive notice of the extension within the original twenty (20) business day review period.

The member and/or provider, as applicable, will receive written notification of the Level II Appeal determination which will include a recitation of the issue, resolution and rationale and, if denied, information regarding the member’s and/or provider’s rights to proceed to a Level III Appeal. If denied, the notification shall include specific instructions as to how the member and/or provider may arrange for an external appeal and shall also include any forms required to initiate such an appeal.

In the event that QualCare fails to comply with any determination for completion of the internal Utilization Management determination appeals set forth above or, in the event that QualCare, for any reason waives its rights to an internal review of any appeal, then the member and/or provider shall be relieved of his/her obligation to complete QualCare’s internal review process and, may, at his or /her option, proceed directly to the external appeal process set forth below as Level III Appeal.

3. Level III Appeal Self-Funded Plans

To initiate a Level 3 Appeal for Self-Funded Plans, a member and/or provider shall, within 30 business days from receipt of the written documentation of the Stage 2 Appeal, file a written request to:

QualCare, Inc.
Utilization Management Appeals Department
30 Knightsbridge Road
Piscataway, NJ, 08854

The Level 3 Appeal will be heard at the next meeting of QualCare’s Board of Directors or may be heard by the member’s employer group specific to the appeals process in the member’s Summary Plan Description.

The right to an external appeal is contingent upon the member’s full compliance with both stages of QualCare’s internal Utilization Management appeal, except for Level III set forth above.
Level III Appeals- Fully Insured Plans (Independent Utilization Review Organization)

To initiate a Stage 3 Appeal for Fully Insured Managed Care Plans, a member and/or provider shall, within 60 business days from receipt of the written documentation of the Stage 2 Appeal.

To initiate an external appeal, a member and/or provider shall, with thirty (30) business days from receipt of the written documentation of the Level II internal appeal, file a written request with the Department of Health and Senior Services. The request shall be filed on the forms provided to the member and shall include both the fee specified below, and a general release executed by the member, for all medical records pertinent to the appeal. The request shall be mailed to:

Department of Banking and Insurance (DOBI)
Consumer Protection Services, Office of Managed Care
P.O. Box 329
Trenton, New Jersey 08625-0329

There is a fee for this level of appeal payable by check or money order to the New Jersey Department of Health and Senior Services. Upon determination of financial hardship, the fee may be reduced. Financial hardship may be demonstrated by the member through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI, or New Jersey Unemployment Assistance.

Upon receipt of the appeal, along with the filing fee and executed release, the Department of Health and Senior Services shall immediately assign the appeal to an IURO for review.

Upon receipt of the request for appeal from the Department of Health and Senior Services, the IURO will conduct a preliminary review of the appeal and accept it for processing, if it determines that:

- The individual was or is a member of the HMO or applicable health benefit plan.

- The service, which is the subject of the complaint or appeal, reasonably appears to be a covered service under the benefits provided by contract to the member.

The member has fully complied with both Level I and Level II Utilization Management appeals’ processes set forth by QualCare, with the following exceptions:

- QualCare did not comply with any of the deadlines for completing the internal Utilization Management determination appeals set forth in Level I and Level II, or QualCare waived its rights to an internal review of the appeal.

- The member has provided all information required by the IURO and Department of Health and Senior Services to make the preliminary determination, including the appeal form and a copy of any information provided by QualCare regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from QualCare and any other relevant health care provider.
Upon completion of the preliminary review, the IURO shall immediately notify the member and/or provider in writing as to whether the appeal has been accepted for processing, and, if not accepted, the reason therefore.

Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of QualCare’s Utilization Management determination, the member was deprived of medically necessary covered services. In reaching this determination, the IURO shall take into consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal Government, national or professional medical societies, boards and associations and, any applicable clinical protocols and/or practice guidelines developed by QualCare.

The full review referenced above shall initially be conducted by a registered professional nurse or a physician licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the Medical Director of the IURO.

The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case, which shall not exceed thirty (30) business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to the member and/or provider, to the Department of Health and Senior Services, and to QualCare, setting forth the status of its review and the specific reasons for the delay.

If the IURO determines that the member was deprived of medically necessary covered services, the IURO shall recommend to the member and/or the provider who filed the appeal, the Department of Health and Senior Services and QualCare or the applicable payor, the appropriate covered health care services the member should receive.

Within ten (10) business days of the receipt of the determination of the IURO, QualCare, the applicable payor, shall submit a written report to the IURO, the member and/or provider who filed the appeal, and the Department of Health and Senior Services, indicating whether it will accept and implement, or reject, the recommendations of the IURO. In the case of a rejection, QualCare, the applicable payor, shall specifically indicate in writing each and every basis for its rejection of the IURO’s recommendation.

QualCare, the applicable payor, may be assessed a cost by the Department of Health and Senior Services for both the initial IURO review and the full IURO review.
<table>
<thead>
<tr>
<th>Dispute Level</th>
<th>Provider / Practitioner Submission Timeframe</th>
<th>QualCare Response Timeframe</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Level 1       | Appeal must be submitted within **180 calendar days.** | Within **5 calendar days** of receiving any additional information supporting the appeal. | Call  
PPO – 1-800-992-6613  
HMO/POS – 1-800-254-0130  
Write:  
QualCare, Inc.  
Utilization Management Appeals Department  
30 Knightsbridge Road  
Piscataway, NJ, 08854 |
| Level 2       | Appeal must be submitted within **60 calendar days** of the date of the Stage 1 decision | Within **20 business days** of receiving any additional information supporting the appeal. | Call  
PPO – 1-800-992-6613  
HMO/POS – 1-800-254-0130  
Write:  
QualCare, Inc.  
Utilization Management Appeals Department  
30 Knightsbridge Road Piscataway, NJ, 08854 |
| Level 3       | Appeal must be submitted within **60 calendar days** of the date of the Stage 2 decision | **Internal Review Process** – Reviewed at the next scheduled QualCare Board Meeting (for Self-insured Plans or as specified in the member’s Summary Plan Description)  
**External Review Process** – for Managed Care Plans follows State laws and regulations of the Members Benefit Plan | **Internal Review Write:**  
QualCare, Inc.  
Utilization Management Appeals Department  
30 Knightsbridge Road  
Piscataway, NJ, 08854  
**External Review Write:**  
NJ Department of Health and Senior Services  
Office of Managed Care  
PO Box 360  
Trenton, NJ 08625-0360 |
Quality Management

Medical Quality of Care (MQOC) Issues:

A Medical Quality of Care (MQOC) issue is any incident of care, which presents as a legal risk due to potential malpractice implications. Malpractice is generally considered to be a deviation from accepted standards of medical care on the part of a provider, which has caused damage to the patient.

Quality of Care issues will be reported to the Continuous Quality Improvement Committee, who in turn will report to the Quality Management Committee on a quarterly basis.

The purpose of the review process is to establish a mechanism to identify and evaluate whether episodes of care meet acceptable standards of medical care, to determine if Health Plan resources are being utilized efficiently and to identify providers with substandard care issues for further peer review at the time of recredentialing.

The UM Quality Review Case Manager requests inpatient and/or ambulatory medical records for MQOC review in writing, by certified mail.

The Medical Director may, at his/her discretion, seek the opinion of a network specialist and/or refer the case to the QualCare Peer Review Committee for assistance in making the final review determination.

The Medical Director assigns an outcome Level of 1 – 4, indicating the severity of the effect upon the patient.

Severity levels are:

Level 1  No quality issue.
Level 2  Confirmed quality issue without potential for significant adverse effect on the patient.
Level 3  Confirmed quality issue with potential for significant adverse effect on the patient.
Level 4  Confirmed quality issue with significant adverse effect on the patient.

If a provider on the list has a Level 3 or Level 4 determination, the case is brought to the attention of the Medical Director and the Provider Services Director for evaluation prior to the meeting. The Credentialing Committee will make a network-participation determination.

The UM Quality Review Care Manager is responsible for the delivery of monthly, quarterly and annual summary reports for each line of business to the Director of Care Management and the Medical Director.

The Utilization Management Care Manager or designee notifies the complainant that an integral review of the complaint/grievance is being conducted and that he/she will be notified of results in writing.
If a QualCare employee or provider is named in the complaint/grievance, a request for information is forwarded to the employee or provider and a written response requested.

In all cases, the internal investigation will be concluded within required 30 days of the receipt of the complaint. Extensions may be made, as they are needed, for thorough investigation and appropriate action and follow up.

The member/provider is notified in writing of the resolution. Instructions regarding his/her right to appeal the decision are also given. Confidentiality is maintained throughout the process.

QUALITY MANAGEMENT /
CONTINUOUS QUALITY IMPROVEMENT PROGRAM (CQI)

QualCare’s Continuous Quality Improvement (CQI) Program is designed to assure that there is a process for covered individuals to receive quality services, medical care, and resolution of identified service issues for both providers and members.

The QM Program is designed to provide members and providers with a comprehensive, formal process for the continuous monitoring, evaluating and improvement of the health and administrative services provided under the health benefit plans served by the QualCare Network.

The scope of the program is comprehensive and includes all activities that have a direct or indirect influence on the quality and outcome of clinical care and service delivered to all members of the applicable health benefit plans served by the QualCare Network and the service provided to employers and provider panel members.

The activities of the Utilization Management, Credentialing, and Peer Review Committees, will be reported to QualCare’s Quality Management Committee (QMC).

Claims, Utilization Management, Network Strategy, Provider Services, Customer Service, Fee Committee and the Administrative and Medical Appeals Committee report data to the Quality Improvement Committee (QIC) on a quarterly basis. The QIC reports activities to the Quality Management Committee which is under the supervision of the Chief Medical Officer and the UM Medical Director.

The Quality Improvement Committee is designed to monitor and evaluate the quality and appropriateness of patient care, identify opportunities for improvement to enhance patient care and resolve identified problems. In order to affect quality health care, QualCare will maintain an ongoing review of quality improvement goals, such as:

1. Provider credentialing standards and procedures.
2. Full compliance with applicable state regulatory guidelines and evidence of JCAHO accreditation for all acute care hospitals with which QualCare contracts.
3. A peer review program conducted by and for participating providers.
4. 24 hour/7 day a week access for care for all members as mandated for Fully-Insured Plans.
5. Physician-enrollee ratios which are reasonable and medically achievable based on membership.
7. Monitoring of appropriate medical records in a current, detailed and confidential manner.
8. Programs of health education and preventive health services for members.
9. Evaluation of member charts with standards of care to detect any program variances.
10. Special studies or audits initiated when problems or unusual patterns are identified.
11. Documentation of corrective action taken and follow-up at specified periodic intervals.
12. A formalized grievance and sanctioning policy.
13. A formalized process for handling members’ suggestions or complaints and identifying, investigating and resolving grievances.
14. Pharmaceutical services, as applicable, in accordance with state and federal regulations; and
15. Establishment of standard criteria for monitoring the quality of medical care through on-site visits and medical record audits.
16. Communication on specific CQI activities is provided via the Provider newsletter.

Provider Compliance, Termination and Appeals Processes

QualCare adheres to policies and procedures for reducing, suspending, or terminating practitioner privileges in compliance with N.J.A.C. 11:24A-4.8 and 4.9. These policies include guidelines for the obligation to report adverse actions taken against providers to the National Practitioner Data Bank (NPDB). The policy includes a provider appeals process. Provider policies have been developed and approved by the QM Committee. The QM Committee reserves the right to revise corporate policies.

TYPES OF TERMINATIONS AND RANGE OF ACTIONS

I. IMMEDIATE TERMINATION
   Notification Requirement: Within 24 hours (within 1 business day)
   Right to Hearing: Yes

   Immediate termination, without prior notice to practitioner will be considered when the following occurs:
   • Practitioner becomes incapable (impaired) of rendering services
   • Practitioner’s license or privilege to practice is revoked, restricted or suspended by the applicable professional licensure board
   • Practitioner’s hospital privileges are revoked for cause
   • Practitioner is disbarred, excluded, or suspended from Medicare/Medicaid
   • Practitioner fails to maintain malpractice insurance as required
   • Practitioner is convicted of a felony
   • Practitioner’s continuation may cause imminent danger to a patient or the public health, safety, or welfare, as determined by a QualCare Medical Director

II. TERMINATION WITHOUT CAUSE
   Notification Requirement: In accordance with the applicable contract (90 or 120 days).
   Right to Hearing: Yes (See Hearing Procedure)

   Termination, with or without cause, may be made at any time, with at least 90 days notice to practitioner, allowing the practitioner an opportunity for peer review panel hearing. Reasons for such termination include, but are not limited to, the following:
• Non-compliance with recredentialing requirements
• Medical Quality of Care issue(s) as determined by the Credentialing Committee
• Non-compliance with Utilization Management/Quality Assurance Policies or requests for information
• Geographical necessity
• Network access
• Practitioner is placed on probation, reprimanded, fined or has privileges restricted by the applicable professional licensure board
• There has been a determination of fraud on the part of the practitioner
• Practitioner’s hospital privileges are suspended or reduced

III. MATERIAL BREACH TERMINATION

Notification Requirement: 30 Days
Right to Hearing: No

A physician may be terminated due to a material breach of the QualCare, Inc. Physician Agreement by giving 30 days’ notice to the practitioner specifying the facts and circumstances of the breach. There will be no opportunity for a hearing. The termination will not take effect if the breach is corrected within 20 days of receipt of the notice, as determined by the VP of Provider Services; however, a reoccurrence of the same or similar incident may result in termination.

IV. SUMMARY SUSPENSION

Notification Requirement: 30 Days
Right to Hearing: Yes

Summary suspension, without prior notice to practitioner will be considered when the practitioner is suspended to prevent harm to patients or reduce the substantial likelihood of immediate danger to the health or safety of patients. The practitioner will remain suspended until proof is received of correction of the issue or resolution by licensure board, courts or QualCare, Inc. Notification will be sent to Licensure Board and NPDB for immediate terminations as approved by the Quality Management Committee.

V. CORRECTIVE ACTION PLAN

Notification Requirement: 30 Days from Receipt of Action Notification
Right to Hearing: Yes

A Corrective Action Plan will be considered when the following occurs:

• Practitioner receives a member complaint for physical appearance and accessibility of practitioner office
• Practitioner receives a complaint or Adverse Issue which includes adequacy of medical treatment and/or record keeping
• Practitioner has a Corrective Action plan due to a complaint or adverse issue for patient safety
Provider will be sent a letter to provide proof that the issue has been corrected. This may include medical record audit, a letter stating changes to office policy or staff or new office forms. If the letter is not sufficient then a corrective action plan will be shared with the Provider.

VI. DENIAL OF INITIAL APPLICATION

<table>
<thead>
<tr>
<th>Notification Requirement:</th>
<th>30 Days from receipt if Action Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Hearing:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The Provider’s initial application is denied when there is an issue on the application. Provider will receive a letter for review to correct any misinformation or document discrepancies.

VII. DENIAL OF REREDENTIALING APPLICATION

<table>
<thead>
<tr>
<th>Notification Requirement:</th>
<th>30 Days from receipt if Action Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Hearing:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The Provider’s recredentialing application is denied when there is an issue on the application. Letters are sent to the Provider for review and to correct any misinformation or document discrepancies. Notification will be sent to Licensure Board and NPDB for Immediate Terminations as approved by the Quality Management Committee.

The Appeal Process

The Appeal Process is initiated by the receipt of the Provider’s written request for an appeal hearing. The request must be sent to QualCare, Inc. attention Credentialing Manager and received within 30 days of the certified Termination Notification letter for prospective terminations. The request must be received within 48 hours for immediate terminations. Appropriate contact information for filing an appeal is included with the termination notice.

Upon receipt of a written request for a Hearing:

1. The Medical Director contacts the appropriate Panel Members to schedule the Hearing.
2. The AVP of Provider Operations or designee will contact the Provider to notify the scheduled date of the Hearing.
3. Minutes will be taken during Hearing.
4. Provider will be given the right to address the ACTION verbally and submit any documentation to support the appeal. The Provider has the right to bring legal counsel if desired. QualCare may choose to have legal representation at the Hearing. Each party may present witnesses and have a right to question the other party’s witnesses.
5. The Provider will be notified via certified mail within thirty (30) business days of Panel’s decision, unless the Panel provides written notice within such thirty (30) day period of a need for an extension for rendering of its decision.
6. All documentation obtained during the Hearing process will be kept confidential.
7. The following information will be documented in the Hearing Panel’s decision:

   a. The relevant contract provisions and the facts upon which the Panel relied upon from the Hearing in determining whether the termination was consistent with the contract terms and QualCare Policy CR 8.
   b. The Panel’s recommendation for corrective action, termination, provisional reinstatement or reinstatement.
   c. The Panel shall state the reason for its recommendation including the reasons for any provisional reinstatement.
   d. If applicable, the Panel shall specify the conditions for reinstatement, the duration of the conditions, and the consequences of a failure to meet the conditions, and the impact it may have upon the terms and conditions of the contract at issue.

The Hearing is conducted by:

   • President and/or designee from the QualCare Administration
   • Vice President
   • Three (3) Network Practitioners, one of which is the same specialty as the practitioner requesting the hearing
   • QualCare legal counsel (optional)
WORKER’S COMPENSATION SECTION
WORKER’S COMPENSATION

IMPORTANT: This information is provided to serve only as a general guideline and can change from health plan to health plan. To confirm what is covered under your patient’s plan design, please call the number listed on the back of their member card.

Workers Compensation
As a full service managed care organization, the QualCare network provides self-funded Workers Compensation plans and carriers access to some of the finest professionals who specialize in treating occupational injuries and illness. QualCare, or the applicable carrier, will coordinate care and provide case management.

The objectives of the QualCare Workers Compensation program are to:

Direct and manage quality medical care to the occupationally injured/ill;
Return employees/claimants back to work as soon as safe and medically appropriate;
Communicate work status information to employers and claim adjusters in a timely fashion;
To address the needs of this unique population in manner that fairly compensates providers but remains cost effective to our clients.

Case Management:
Nurse case managers act as the coordinators of all medical services for the employee/claimant, as well as the hub of communications for the employer and claim adjuster, as they:

Review treatment plans
Authorize medical care
Oversee utilization management
Maintain open lines of communication with providers, employees/claimants, employers & claim adjusters.
Communicate employee/claimant work status to the employer & claim adjuster
Establish pharmacy services
Make arrangements for durable medical equipment

What to expect - Initial Interaction:
QualCare or the applicable carrier will typically contact your office to inform you that an employee/claimant is coming (if you are a walk-in facility) or to schedule an appointment.

At the time of initial contact, QualCare or the applicable carrier will provide you with additional information regarding necessary authorizations, pre-certifications, and medical documentation necessary to treat the occupationally injured claimant. If an injured worker presents without advance contact, gather the appropriate information from the employee/employer regarding who you should contact for billing information and to begin the case management process.

Primary/urgent/occupational care is to be made immediately available.

Specialty appointments are to be made available within 72 hours of the request.
QualCare Case Management

QualCare services for reporting of injuries and medical referrals are operational 24 hours per day/7 days per week/365 days per year, including holidays. Availability and accessibility to medical services is a key component in the success of our program. You may contact QualCare for Workers’ Compensation questions at:

Workers’ Compensation Department Phone: 1-800-425-3222
Workers’ Compensation Clinical Unit & Bill Processing fax: 1-732-562-2815

QualCare Duty Determination Instructions (DDI):

Prior to each medical encounter, QualCare will fax to your office a Duty Determination Instruction form (DDI) and Pre-certification letter. These forms will act as an authorization to treat the employee/claimant.

The DDI form is a QualCare tool used to quickly gather medical diagnosis/treatment and work status information and to communicate it to employers and claims adjusters. The top portion of the form will come to you complete with employee/claimant information such as name, date of injury, social security number, date of visit, body part, pre-certification number, claim number, and service authorized.

Upon evaluating the employee/claimant, QualCare requires you to complete the bottom portion of the form paying particular attention to:

- Diagnosis/ICD9 Code
- Treatment plan
- Level of function
- Date of return visit (if applicable)
- Request for specialist referral
- Anticipated discharge date (when appropriate)

QualCare works with its clients to identify alternate duty assignments for the employee/claimant during the treatment period. Therefore, QualCare requires that you evaluate the employee/claimant in terms of functional capacity, providing specific information in the areas of lifting, standing, walking, sitting, driving, use of hands and arms, bending, twisting, climbing and reaching. A copy of a DDI form is attached at the end of this section, for your reference.

Medical Documentation:

DDI Form Completion

It is critical that the DDI form be completed in its entirety and promptly returned to QualCare, as any delay in this process can interrupt employee/claimant benefits. This form must be completed at the time of the claimant’s office visit and faxed to the case manager indicated on the form within 24 hours of the visit.

Please note that employee/claimant benefits are also contingent upon his/her compliance with medical treatment programs. If the employee/claimant misses an appointment please note that on the bottom of the DDI form and forward it to QualCare immediately. This information is carefully tracked as benefits can be suspended due to non-compliance.
Medical Notes:
Medical dictation including impressions, recommended treatment plan, work status, anticipated date of maximum medical improvement and return-to-office information should be provided to QualCare within 7-10 days following an office visit.

Pre-certification for all Procedures:
Please note that pre-certification is required for all non-emergent services, including, but not limited to:
- Diagnostic tests
- Physical Therapy / Occupational Therapy
- Surgery
- In-patient procedures
- Durable medical equipment

Physical/ Occupational Therapy

When ordering physical /occupational therapy, a prescription must accompany the DDI form you forward to QualCare.

Surgical Authorizations:

When non-emergent surgery is indicated, please advise QualCare using the space provided on the bottom right of DDI form. A Surgery Authorization Form (see attachments) will be forwarded to you and for completion and return to QualCare prior to the procedure date.

**NOTE:** All procedures must be performed at a QualCare network hospital/facility.

Once you have submitted the form, it will be reviewed by QualCare’s Medical Director. Notice of authorization or denial will be provided within 48 hours. Information the form requires includes:

- Diagnosis
- Name of Surgical Procedure
- Anticipated ICD codes & modifiers to be billed
- Date of Surgery
- Date of PATs
- Surgery Location
- Ambulatory/Same Day or Inpatient/ Projected Length of Stay
- Projected Return to Work Date
- Request for Assistant Surgeon*

*Assistant and co-surgeons will not be approved without prior authorization.

Specialist Referrals:
If you determine that a referral for additional medical services is necessary, you must advise the case manager handling the file of the referral need. The case manager will identify a network provider to fit the referral need and make all arrangements related to appointments. Referrals made directly to another provider are not permitted.
Billing:
In Workers’ Compensation, there are no co-payments of any kind. Payments from Claims Administrators constitute payment in full for the services rendered.

**PLEASE BE REMINDED THAT NEW JERSEY LAW PROHIBITS YOU FROM DIRECTLY BILLING WORKERS’ COMPENSATION PATIENTS FOR SERVICES RENDERED. THIS MEANS THAT YOU MAY NOT BILL PATIENTS FOR CHARGES OR THE BALANCE BETWEEN ACTUAL CHARGES AND THE ALLOWABLE AMOUNT.**

To expedite payment of bills, use the pre-certification number provided on our Duty Determination Form when submitting CMS 1500 forms related to services. Include dictated medical notes. Forward all medical claims to:

**QualCare**
**PO Box 309**
**Piscataway, NJ 08855-0309**
**Att: Workers’ Compensation Department**
QUALCARE

Duty Determination Instructions
P.O. Box 309, Piscataway, NJ 08855
Phone # 800-425-3222 Fax 732-562-2815
Case Manager:

URGENT! PLEASE FAX WITHIN 24 HOURS OF PATIENT VISIT!

Employee: __________________________ Authorization #: __________________________
Employer: __________________________ Case Manager: __________________________
Job Title: __________________________ Date & Time of Visit: __________________________

Employee's Initial Complaint:

**Please indicate below the level of physical activities required during the treatment period:**

<table>
<thead>
<tr>
<th>Indicate level of physical activity:</th>
<th>In an 8 hour day, the employee may:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No restrictions of job activities required. Concurrent therapy may be required, but all essential job functions may be performed safely and without harm to person.</td>
<td>Stand/Walk (hours/day): 1-4 hours 1-3 hours 4-6 hours 3-5 hours 6-8 hours 5-8 hours Other Other</td>
</tr>
<tr>
<td>Requires severe restrictions to physical activities that includes bed rest and restriction to home only. Person is allowed to go to doctor's office and therapy only.</td>
<td>Drive (hours/day): Cannot drive Single grasping &lt;1 hour Pushing/pulling 1-3 hours Fine manipulation 3-5 hours Other 5-8 hours</td>
</tr>
<tr>
<td>Sedentary work. Lifting up to 10 lbs. maximum. This level if activity requires primarily sitting with a small amount of standing and walking.</td>
<td>Type of vehicle allowed:</td>
</tr>
<tr>
<td>Light work: Lifting up to 20 lbs. maximum &amp; or carry 10 lbs. frequently. Will allow walking and standing as needed. Also will allow pushing/pulling with arms only, and/or leg or foot.</td>
<td>Person may use foot repetitively: yes no</td>
</tr>
<tr>
<td>Light medium work: Lifting 30 lbs. max. frequently &amp; or carry of objects up to 20 lbs. Approximate # of lifts per hour allowed:</td>
<td>Indicate restrictions in the following:</td>
</tr>
<tr>
<td>Medium work: lifting 50 lbs. max. frequently &amp;/or carrying of objects up to 25 lbs. Approximate # lifts per hour allowed:</td>
<td>Bending to floor level</td>
</tr>
<tr>
<td>Light heavy work: Lifting 75 lbs. max. frequently &amp;/or carry objects up to 40 lbs. max. Max. lifts per hour:</td>
<td>Twisting to transfer object</td>
</tr>
<tr>
<td>Heavy work: Lifting up to 100 lbs. max. &amp;/or carry objects up to 50 lbs. Max. lifts per hour:</td>
<td>Squatting below chair level</td>
</tr>
</tbody>
</table>

*The above restrictions are in effect until (date): __________________________ Next Appt. Date: __________________________
Approximate Return to Work Date: __________________________

DX: __________________________
TX Plan: __________________________ Causally related: yes no
PT: __________________________ Surgery: __________________________

Name of Provider: __________________________ (Please Print)
Signature: __________________________

DC DD1 form
082700 SB
GLOSSARY
Important Terms and Definitions

1. “Carrier” means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17-4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A-1 et seq., a health services corporation authorized to transact business in accordance with N.J.S.A. 17:48E-1 et seq., or a health maintenance organization authorized to transact business pursuant to N.J.S.A. 26:2J-1 et seq.

2. “Clean Claim” means a claim that has been delivered to the proper billing address, and has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim. Policy details can be found at www.qualcareinc.com click on Provider and review our Documents & Forms page.

3. “Co-Insurance” is the percentage of a Provider’s reimbursement hereunder for which the Member is responsible each time the Member receives a service, after the Deductible is satisfied.

4. “Coordination of Benefits” or “COB” means the administrative provisions and determinations utilized among Health Benefits Plans to avoid duplicate payment of claims when a Member is covered by more than one health plan or form of insurance.

5. “Co-Payment” is a cost sharing arrangement in which the Member is required to pay a specified amount for a specific health service such as an office visit, outpatient prescription or emergency room visit, usually paid at the time of service.

6. “Covered Services” means Medically Necessary services and supplies which a Member is entitled to receive as described under a Health Benefits Plan. Services which are not Medically Necessary shall not be deemed Covered Services for purposes of this Agreement or the Health Benefits Plan, except as provided herein.

7. “Deductible” means the amount a Member pays out-of-pocket each year before the Health Benefits Plan begins to pay for services provided.

8. “Emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an
Emergency exists where: there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child. Emergency services include a medical screening examination and inpatient and outpatient services that are needed to stabilize an Emergency medical condition.

9. “Fully insured” mean an employer pays a fixed monthly premium to a health insurance company to take financial risk for their claims and provide and administer benefits plans for its employees. This means the insurer, not the employer, is liable for the cost of medical claims. Fully insured plans are under the regulatory auspices of the Department of Banking and Insurance.

10. “Health Benefits Plan” or “Plan” means a contract or policy that pays or provides coverage for hospital or medical services, or payment for expenses therefore, and which is delivered or issued for delivery in New Jersey by or through a Payor.

11. “Hospital Services” means those inpatient, emergency, outpatient or other health care facility services which are generally and customarily provided to patients by or through a hospital or its affiliated health care facilities.

12. “Material” with respect to an amendment to this Agreement means a change that QualCare determines could reasonably be expected to have a substantial adverse impact on Physician’s reimbursement for Covered Services hereunder.

13. Medically Necessary” means the use of services and/or supplies as determined by the Utilization Management and Quality Assurance Programs that: i) are consistent with the symptoms or diagnosis and treatment of a Member’s condition, disease, ailment or injury or are preventative Covered Services; ii) are in accordance with approved and generally accepted medical or surgical practice; iii) are not solely for the convenience of a Member or healthcare Provider; and iv) are the most appropriate level of services which can be safely provided to the Member. When specifically applied to an inpatient admission it further means that the diagnosis or treatment can best be safely provided to such Member on an inpatient basis.

14. “Member” means a person who is enrolled in a Health Benefits Plan, including enrolled dependents, and eligible to receive Covered Services under the terms of a Health Benefits Plan.

15. “Participating Hospital” means a duly licensed health care facility, including but not limited to, hospitals, outpatient clinics, emergicenters and skilled nursing facilities that has entered into an agreement with QualCare to provide Covered Services to Members.

16. “Participating Physician” means a physician or practitioner duly licensed, certified or otherwise authorized to practice within the scope of such license or authorization who has entered into an agreement with QualCare to provide Covered Services to Members, and who has privileges to admit patients to the acute care facilities of at least one Participating Hospital.
17. “Participating Provider” means a Participating Hospital, Participating Physician and/or other Provider that, under a contract with QualCare, has agreed to provide Covered Services or supplies to Members for a predetermined fee or set of fees.

18. “Payor” means a Carrier, third-party administrator, or self-funded plan that is contractually obligated under a Health Benefits Plan to make payment on behalf of Members with respect to Covered Services.

19. “Physician Services” are those health care services which can be provided by a duly licensed physician or practitioner as part of the physician’s or practitioner’s legally permitted practice.

20. “Primary Care Provider” or “PCP” means an individual Participating Provider who supervises, coordinates and provides initial and basic care to Members and maintains continuity of care for Members.

21. “Primary Care Services” means those Covered Services determined to be primary care services by QualCare, and/or the applicable Payor.

22. “Provider” means a physician, other health care professional, health care facility or any other person who is licensed or otherwise authorized to provide health care services within the scope of his or her license or authorization in the state or jurisdiction in which the health care services are rendered.

23. “Quality Management” or “QM” means the process of measuring, evaluating and improving the provision of quality medical services, procedures and facilities to Members.

24. “Referral” means the process by which a Primary Care Provider directs a Member to seek and obtain Covered Services from a health professional, a hospital or any other Provider of Covered Services.

25. “Self funded health plan” means an employer takes on the financial responsibility of paying the health benefits claims of its employees versus a "fully insured" employer, who pays a health insurance company a fixed monthly premium to take on financial risk and responsibility for claims. Self-insured plans can be administered by the employer or more often, by an outside company called a Third Party Administrator (TPA). The TPA will usually provide members with ID cards and Plan Descriptions, maintain enrollment information, as well as processing claims and issuing the Explanations of Benefits (EOBs). The self funded employer group is responsible for transferring the funds for claims payment to the TPA, who will then issue the claims reimbursement checks. If the employer group does not transfer the funds to pay a claim, the TPA is under no obligation to pay the claim. Self funded plans are under the regulatory auspices of ERISA and federal law.
26. “Specialist Physician” means a Participating Physician who is professionally qualified to practice his or her designated specialty and whose agreement with QualCare includes responsibility for providing Covered Services in his or her designated specialty upon Referral from a Primary Care Provider.

27. “Urgently Needed Services” means services required to prevent a serious deterioration of a Member’s health that results from an unforeseen illness, injury or condition that requires care within twenty-four (24) hours.

28. “Utilization Management” or “UM” means a system for reviewing the appropriate and efficient allocation of health care services under a Health Benefits Plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a Member should or will be reimbursed, covered, paid for, or otherwise provided under the Health Benefits Plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.