QUALCARE PROVIDER MANUAL

QUALCARE®

Dear Valued Provider,

Welcome to QualCare, Inc.!

The primary objective of QualCare is to offer clients and members access to high-quality medical care in a cost-effective environment. Success of the QualCare mission depends upon your support of this health network alternative.

The QualCare network offers fully insured carriers network access, provider credentialing, and claims repricing. The QualCare network access model includes the QualCare health maintenance organization/point of service (HMO/POS) network and/or the QualCare preferred provider organization (PPO) network.

This manual is designed to provide you and your office staff with information regarding the administrative processes for providing care to network access members. From time to time, there may be new information or changes in established policies and procedures. We will let you know about these changes as quickly as possible to ensure proper administration.

Our network includes more than 40,000 physicians and providers as well as 100 acute, specialty, and rehabilitation hospitals. Please access our online 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 ensuring that your participation in QualCare is a positive and beneficial experience. Please contact QualCare's Provider Relations department at 800.992.6613 if you have any questions or concerns.

Thank you for your participation. We look forward to working with you and your office staff.

Table of contents

Quick Reference Contact Information

Corporate Mailing Address

QualCare, Inc.
30 Knightsbridge Road
Piscataway, N.J. 08854

Corporate Main Number

800.992.6613

Claims Address

Please forward claims to the address on back of the patient's member ID card or electronically using the payor ID number.

Directory of Participating Providers

QualCare's comprehensive network ensures that members will have their medical needs 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 available online at **qualcareinc.com**.

Eligibility Information - Integrated Voice Recognition (IVR) System/NaviNet

For active members for whom QualCare manages enrollment information, you can verify eligibility or check on claim status online via NaviNet (**navinet.navimedix.com**) or by calling the number on the back of the member ID card.

Member Services

For questions about benefits and/or policies and procedures, call the number listed on the back of your patient's member ID card.

Provider Relations

The Provider Relations department is available to offer assistance with:

- Training for office staff
- Claims review
- Contract inquiries
- Compliance and education
- Demographic maintenance

Please call 800.992.6613 for assistance.

The Network

QualCare History and Overview

QualCare was founded in 1991 as a preferred provider organization (PPO) by SSM Health Care Ministry Corporation and St. Clare's Physician Organization, Inc. It was called Preferred Providers of New Jersey, Inc. (PPNJ) and 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 nonsponsor hospitals and providers. 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.

QualCare makes affordable, quality health care available to carriers who want a comprehensive network of exceptional providers.

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 these responsibilities. The information below is a brief highlight of our respective commitments.

The QualCare Commitment

- We strive to balance the need for equitable reimbursement for our providers.
- We will work to provide the best service possible to our providers. We value this relationship and recognize the need for our continued success.

Our Participating Providers' Commitment

- See and treat 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;
- Submit complete and timely claims;
- Work cooperatively and collaboratively with QualCare and client cost containment programs, including preauthorization or certification, concurrent review, case management, etc.

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 health care 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, (Council on Affordable Quality Healthcare® accepted) and an approval/denial process. The following documents must be included by the provider as part of the completed application:

1. Signed and dated application/recredentialing application.
2. Education and training.
3. Work history/resume, including start and end dates and an explanation of any gaps longer than six months.
4. Licensure – legible copy of unrestricted current New Jersey state and all other applicable state licenses.
5. Drug Enforcement Agency (DEA) Registration – legible copy of current DEA registration.
6. CDS Registration – legible copy of current CDS certificate.
7. Malpractice Coverage – legible copy of current malpractice face sheet with coverage of $1 million per occurrence and $3 million aggregate.
8. Board Certification (if applicable) – legible copy of board certificate, if applicable.
9. Hospital Privileges – indicates primary admitting hospital and all other admitting hospitals, if applicable. Hospital privileges must be at a QualCare participating hospital.
10. 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.
11. 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 the National Committee for Quality Assurance (NCQA). Verification is performed on the above required documents, plus sanctions and malpractice history as needed.

Required documents must be no older than 180 days.

All malpractice cases, adverse National Practitioner Data Bank (NPDB) responses, adverse notifications received from other sources, and site-visit issues are reviewed and forwarded to the medical director as needed. 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 QM Committee. Tabled files are updated before being presented at the next Credentialing Committee. Denied applicants may apply again in 12 months.

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 or request reconsideration of Credentialing department decisions upon written notification.

Recredentialing Process

All providers in QualCare are recredentialed 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 not recredentialed will not be renewed.

Please 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.

Benefit Coverage, Exclusions, and Limitations

Covered Services

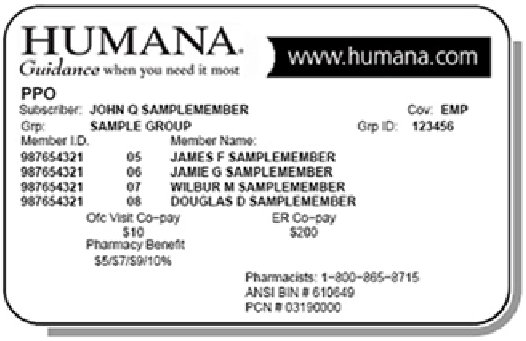
Please contact the network access client to determine which services and items are covered.

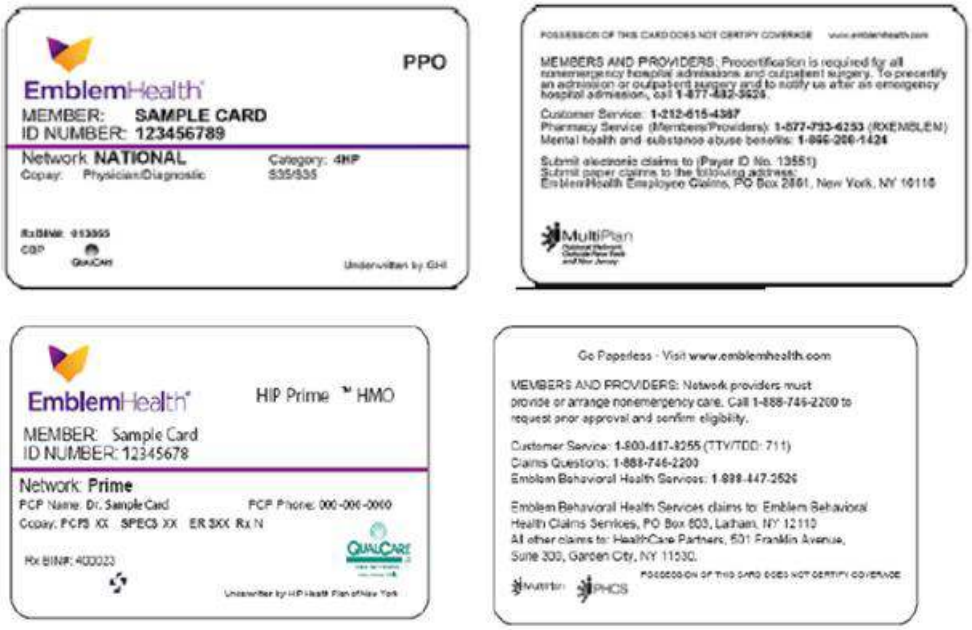
Sample ID Cards

Front

Back - Individual

Back - Small group





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.

Benefits and eligibility information may be obtained by contacting the network access member's plan directly. Please see the network access websites below, which may also be useful for obtaining current contact information. These clients may offer member eligibility through a secured online portal, interactive voice response system, and/or live telephone operators.

- **hioscar.com/providers/resources**
- **emblemhealth.com/providers**
- **humana.com/provider/**

Physician Services/Plan Providers

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
- Providers in the Group
- Office Hours
- Panel Closing
- Tax ID Number
- Covering Provider Arrangements
- Billing Address
- Reduction in Services
- Admitting Privileges

Written notices should be sent to:

QualCare, Inc.
30 Knightsbridge Road
Piscataway, N.J. 08854
Attn: Provider Relations

Fax notices should be transmitted to:

732.562.7868
Attn: Provider Relations

Email notices should be sent to:

qcprovrel@qualcareinc.com

Primary Care Providers (PCP)

Role of the Primary Care Provider

The Primary Care Provider (PCP) is responsible for helping to manage the health care of his/her assigned members. QualCare PCPs are reimbursed through a fee-for-service model regardless of benefit plan design.

Availability

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

Responsibilities

- Confirm member eligibility and benefit coverage.
- Ensure that requested hospitals and referring physicians are participating providers.
- Evaluate medical necessity, proposed place of treatment, and treatment plan.
- Review and confirm the specialist treatment plan as appropriate.
- 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 carrier to facilitate coverage decisions.

Referrals to Nonparticipating Providers, including Ambulatory Surgical Centers and Freestanding Laboratories

As part of your contract with QualCare, you agree to refer your patients to other in-network physicians, hospitals, and other providers and facilities. It is understood there are some exceptions, for example, in an emergency or if services cannot be provided within the network. It is our expectation that you will partner with the members you see through your QualCare participation to help them maximize their benefits by referring additional care to other participating providers. Otherwise, when a patient is referred to a nonparticipating provider, the patient may incur unexpected financial liability.

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 a health maintenance organization (HMO) model or point of service (POS) coverage when required, except when the 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.

Responsibilities

The specialist is responsible for the following:

- Verifying that prior authorization has been obtained before rendering services, if required. (Services rendered without required prior authorization may result in denied claims. The member should not be billed.)
- The specialist should always verify member's eligibility before rendering services.
- The specialist must always provide a designated PCP with follow-up information when a PCP is identified.

Referrals to Nonparticipating Providers, including Ambulatory Surgical Centers and Freestanding Laboratories

As part of your contract with QualCare, you agree to refer your patients to other in-network contracted physicians, hospitals, and other providers and facilities. It is understood there are some exceptions, for example, in an emergency or if services cannot be provided within the network. It is our expectation that you will partner with the members you see through your QualCare participation to help them maximize their benefits by referring additional care to other participating providers. Otherwise, when a patient is referred to a nonparticipating provider, the patient may incur unexpected financial liability.

Advance Directives

Providers in HMO Network

Providers who participate in QualCare's HMO network are required to provide information on advance directives to their patients.

Advance directives help providers identify someone authorized by the patient to make decisions on the patient's behalf in a crisis situation. An advance directive also may allow providers and family members to make decisions for treatment based on the patient's 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, they are available from a number of sources, including certain social service agencies, and the New Jersey Department of Health.

To obtain a Health Care Proxy form from the New Jersey Department of Health, visit their website at **state.nj.us/health/advancedirective/ad/forums-faqs/**.

Provider Availability Standards

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

Type	Access Standard
Emergency (See Glossary)	Immediate access, 24 hours a day, 365 days a year
Urgent	24 hours or less
Routine Care	Two weeks or less

Type	Access Standard
Preventive Physical Exams	Four months or less

Network providers are responsible for ensuring 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 of their participation agreement, including acceptance of QualCare's agreed upon fee schedule as payment in full.

Claims and Billing Information

Provider Reimbursement

Primary Care Provider

PCPs are reimbursed on a fee-for-service basis and paid according to the fee schedule outlined in the QualCare Provider Agreement.

Specialist Providers

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

Please note: Each provider 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 copayments, coinsurance, or deductible amounts.

Copayments

A copayment is a specific dollar amount paid by the member for a specific health service such as an office visit, outpatient prescription, or emergency room visit. The required copayment amount will be indicated on the member's ID card. Please call the number for the Member Services department on the ID card to verify copayment amounts.

It is the responsibility of the provider's office to collect the copayment at the time of service. Any copayment collected should be reflected on the claim form submitted.

Billing the Patient

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

The provider is responsible for collecting any copayments, deductible, or coinsurance amounts. The provider may also bill the member directly for any services that are not covered under the patient's health benefit plan if the provider has informed the member prior to rendering the service that it 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.

The provider may not bill members for services that are determined through utilization management not to be medically necessary unless the provider 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 800.992.6613.

Claims Submission and Payment

The preferred method of submitting claims is electronically. Claims submitted via electronic data interchange (EDI) result in faster turnaround times than those submitted on paper. The NEIC Payer IDs can be found on the back of the member's ID card and as follows:

- Oscar Health: OSCAR
- Emblem Health: 13551
- Humana: 61101

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 copayments 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 according to network access plan guidelines.

- **hioscar.com/providers/resources**
- **emblemhealth.com/providers**
- **humana.com/provider/**

Office Visit vs. Consultation

According to the current official American Medical Association's CPT® (Current Procedural Terminology) 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 provider. When you see a patient for consultation (as defined above), the **CPT 99241-99245** series should be used.

Coding for Preventive Services

Correctly coding preventive care services is essential for receiving accurate payment. Submit the preventive care services with an ICD-10 code that represents health services encounters that are not for the treatment of illness or injury.

- Place the ICD-10 code in the first diagnosis position of the claim form.
- Preventive care service claims submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim will be paid as applicable under normal medical benefits rather than preventive care coverage.
- Non-preventive care services incorrectly coded as "Preventive Medicine Evaluation and Management Services" will not be covered as preventive care.

Annual Gynecological Exam and Pap Test

Use the appropriate preventive care codes (99384-99387, 99394-99397) for annual gynecological exams with Pap tests. Do not bill for the Pap test separately using the pathology code series 88XXX or Q0091. The cost of obtaining the Pap specimen is included with 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)

- **hioscar.com/providers/resources**
- **emblemhealth.com/providers**
- **humana.com/provider/**

Services That Do Not Require a Referral Form or Precertification

The following are services that do not require a referral form:

- Laboratory services: Must supply laboratory with a fully completed requisition form, including member's name, ID, health benefit plan, employer name, and group number.
- OB/GYN: Enrolled members can access obstetrical/gynecological services without obtaining prior authorization and/or referral.

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, and address.
2. Health benefit plan, employer identification number, group name and number, if indicated.
3. Information on other insurance or coverage. Also include a 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.

Provider or Supplier Information:

1. The name of the provider who referred the patient, if applicable.
2. Diagnostic code and brief description. If ICD-10 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 customary charge for each procedure listed, along with total charges for the claim. Also include any copayments 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 National Provider Identifier (NPI) number for the provider performing the services.
10. Name, signature, and address of provider performing services.
11. A referral form must be attached for specialist visits, as required by plans for applicable HMO and POS members.

Submitting Claims

Please reference the address on the back of the member's card to determine where claims should be sent. Because this information may vary from patient to patient, it is critical for timely and accurate claims processing that the provider refer to each member's ID card.

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 service/discharge will result in forfeiture of all rights to bill the payor or member for such services.

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

Claims Payment

Under circumstances that require coordination of benefits or a claims review process, claims payment may be delayed until all necessary information is received.

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 telephone number on the voucher, or the Member Services number listed on the member's ID card. For additional assistance, please call QualCare's Provider Relations department at 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 the section entitled, "Provider Disputes/Complaints" for information on how to file a dispute or complaint.

Ancillary Services

These ancillary services are subject to the following guidelines unless otherwise specified:

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 copayment 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 number.

QualCare maintains a listing of lab tests that are covered when provided in a provider's office. Lab tests not listed will not be reimbursed by the plan and a member cannot be balanced billed for this service.

QualCare's exclusive laboratory is Quest Diagnostics, 800.225.7483.

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

Billable Lab Services

Provider offices with appropriate Clinical Laboratory Improvement Amendments (CLIA) approval may perform and bill the following lab services in their offices:

CPT Code	Description
80198	Theophylline
80305 and 80306	Drug screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation, including instrument-assisted when performed (e.g., dipsticks, cups, cards, cartridges), per date of service
81000	Urinalysis
81002	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81007	Bacteriuria screen, except by culture or dipstick
81015	Microscopic only
81025	Urine pregnancy test, by visual color comparison methods
82010	Acetone or other ketone bodies, serum; quantitative
82044	Albumin; urine, microalbumin, semiquantitative (e.g., reagent strip assay)
82120	Amines, vaginal fluid qualitative
82270	Blood; occult, feces screening, one to three simultaneous determinations
82272	Blood, occult, by peroxidase activity (e.g., guaiac)
82271	Other sources
82274	Fecal blood occult
82550	Gases, blood, any combination of pH, pCO2, PO2, CO2, HCO3, (including calculated 02 saturation)
82948	Glucose; blood, reagent strip
82962	Glucose, blood by glucose monitoring device(s) cleared by the U.S. Food and Drug Administration (FDA) specifically for home use
83026	Hemoglobin; by copper sulfate method, non-automated
83518	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single- step method (e.g., reagent strip)
83986	pH, body fluid, except blood – vaginal rare

CPT Code	Description
85002	Bleeding time
85007	Blood CT manual, differential white blood cell WBC count (WBC)
85008	Blood count manual smear examination without differential parameters
85013	Spun microhematocrit
85014	Blood count; other than spun hematocrit
85018	Hemoglobin
85025	Hemogram and platelet count, automated and automated complete differential WBC count (CBC)
85027	Blood count complete (CBC), automated (Hgb, Hct, red blood cell count (RBC), WBC and platelet count)
85049	Automated count
85610	Prothrombin time
85651	Sedimentation rate, erythrocyte; non-automated
86318	Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (e.g., reagent strip)
86403	Rapid strep test partial agglutination; screen, each antibody
86485	Skin test; candida
86580	Tuberculosis, intradermal
86585	Tuberculosis, tine test
87081	Culture, presumptive, pathogenic organisms, screening only
87086	Culture, bacterial; quantitative colony count, urine
87164	Dark field examination, any source (e.g., penile, vaginal, oral skin); includes specimen collection – rare
87168	Macroscopic examination; arthropod
87172	Pinworm exam (e.g., cellophane tap prep)
87205	Smear, primary source with w/interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87210	Wet mount for infectious agents (e.g., saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)
87275	Influenza B virus
87276	Influenza A virus
87400	Influenza A or B, each
87430	Streptococcus, group A

CPT Code	Description
87804	Infectious agent antigen detection by immunoassay with direct optical observation; influenza
87880	Streptococcus, group A
89050	Cell count, miscellaneous body fluids (e.g., cerebrospinal fluid, joint fluid, except blood)
89051	With differential count
89060	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)
89190	Nasal smear for eosinophils
89300	Semen analysis; presence and/or motility of sperm, including Huhner test (post coital)
G0107	Colorectal cancer screening; fecal --- occult blood test, one to three simultaneous determinations

*Please note that specialists may be privileged to perform additional laboratory testing specific to their area of practice. Please contact the Provider Relations department at 800.992.6613 if you have any questions.

Radiology

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

Please note that radiation therapy, magnetic resonance imaging (MRIs), magnetic resonance angiograms (MRAs) and positron emission tomography (PET) scans may require precertification by some carrier's UM departments. For the 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 **qualcareinc.com** or call Provider Relations at 800.992.6613.

Mental Health and Substance Abuse

- **hioscar.com/providers/resources**
- **emblemhealth.com/providers**
- **humana.com/provider/**

Prescription Benefits

- **hioscar.com/providers/resources**
- **emblemhealth.com/providers**
- **humana.com/provider/**

Health Insurance Portability and Accountability Act (HIPAA)

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 Medicare and

Medicaid Services (CMS) formally known as the Health Care Finance Administration is responsible for implementing various provisions of HIPAA.

One provision of HIPAA that impacts health care organizations is the Administrative Simplification Act. It is intended to reduce the costs and administrative burdens of health care by making standardized electronic transmission possible for many administrative and financial transactions that are frequently processed on paper. Also included 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 HIPAA 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 2003 made 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 5010. The addenda also adopted 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:

- Claims or equivalent encounter information
- Payment and remittance advice
- Claim status and inquiry response
- Eligibility inquiry and response
- Referral certification and authorization inquiry and response
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- 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.[2] For detailed information about HIPAA, log onto the CMS HIPAA website at **cms.gov**.

Privacy Overview

The Privacy Rule became effective on April 14, 2003. Most health plans and health care providers covered by this rule had to comply with the new requirements by this date. 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 noncompliance. The design and implementation of your plan should be reasonably developed based on the size of your organization and the complexity of complying with HIPAA privacy regulations.

[1] 45 C.F.R. § 160.103
[2] Source: CMS HIPAA Information Series

Security Overview

The security standards work in concert with the final privacy standards adopted by the U.S. Department of Health and Human Services (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 by April 21, 2005.

Unique Identifier 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.

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 that 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 content is 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 is maintained at the provider's practice site.

Medical Records Standards

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

Organization

The record is to be organized as follows:

- Each member's medical record must be individually trackable.
- The record is secured to maintain confidentiality.

- There is a section for patient identification that includes name, age, gender, employer, occupation, work and home telephone numbers, insurance information, and marital status.
- Every page in the record should contain the member's name or ID number.
- All entries contain author identification, are legible, and dated.

Documentation

The following information is to be documented:

- Medication allergies and adverse reactions are noted in a consistent, prominent place.
- 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.
- Problem lists are used for members with significant illnesses and/or conditions that should be monitored. A chief complaint and diagnosis or probable diagnosis is included.
- There is documentation of an exam appropriate for the condition.
- All medications prescribed are noted with name, dosage, frequency, and duration.
- Medications given on-site are noted with name, dosage, route, as well as the site given and batch number.
- Treatments, procedures, tests, and results are documented.
- Member education, recommendation, and instructions given are included.
- Member records have a completed immunization record or an up-to-date notation of immunizations.

Completeness

The following is done in a timely manner:

- The medical record is checked to ensure that all ordered procedures and referrals are returned and filed in the chart in a timely fashion commensurate with referral or procedure.
- The provider reviews and initials all test results and consultations within seven or fewer working days, as appropriate.

Medical Record Review

- Opportunities to improve care/service are included in the provider's Quality Profile for use at the time of recredentialing.
- 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 Complaints Procedure

Providers may register complaints by contacting the Provider Relations department by telephone, or in writing via mail, email, or fax, as follows:

Written notices should be sent to:

QualCare, Inc.
30 Knightsbridge Road
Piscataway, N.J. 08854
Attn: Provider Relations

Fax notices should be transmitted to:

732.562.7868
Attn: Provider Relations

Email notices should be sent to:

qcprovrel@qualcareinc.com

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

1. Provider contact information, including address, and telephone and fax numbers.
2. Your office contact person's name and title.
3. Your Taxpayer Identification Number.
4. Clear description of the complaint.
5. Preferred contact times for follow-up with your office.

QualCare is dedicated to resolving provider complaints promptly, whenever possible. Generally, such responses will be made in the same manner as they were received, by telephone 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 about how to file a claim dispute or complaint.

- **hioscar.com/providers/resources**
- **emblemhealth.com/providers**
- **humana.com/provider/**

Additionally, providers may register complaints with QualCare that relate to service, policies and procedures of a payor or carrier accessing the QualCare network. For assistance concerning where to file a dispute/complaint, contact Provider Relations at 800.992.6613. These complaints are tracked and forwarded to the carrier for resolution with the response to the provider coordinated by QualCare.

Utilization Management Denial Process

A consistent procedure is followed by QualCare's Utilization Management (UM) staff to inform providers and members about requests for coverage of services that are denied. The procedure includes notification of QualCare's appeals process as well as the implementation of the appeal process.

UM staff will send denial letters to providers and members after the medical director or designated physicians have reviewed and determined the coverage 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 by 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 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 letters explain the reasons for the denials and the medical criteria used to support them.

Denials of coverage for services may be based upon various grounds including the following:

- The provider is not contracted with QualCare.
- 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.
- The member is not eligible.

- The service is not a covered benefit.
- The member's benefits for that service have been exhausted.
- The services can be provided by a participating provider.
- The services can be provided at an alternate level of care.
- The referring physician is not contracted with QualCare.
- The service requested is not consistent with QualCare's medical and administrative policies.
- The provider is not capable, based upon information concerning 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 consult the carrier for additional information.

Utilization Management Appeal Process

The provider 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 depending upon the underlying benefit plan. Self-funded plans are generally subject to the Employee Retirement Income Security Act of 1974 (ERISA) and insured plans are regulated under state law.

Level I Appeal (Informal Internal Review)

QualCare maintains an 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.

Please note: No provider may be terminated or penalized solely for filing a complaint or appeal.

Level I appeals may be submitted verbally (over the telephone) or in writing.

Level I preservice or concurrent care 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 generally five business days in the case of all other appeals. The requirement is 10 calendar days for non-urgent/emergency issues (no extension available; for both pre- and post-service 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.

Initially, the response process may be 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.

Level II Appeal (Formal Internal Review)

QualCare offers a second 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 option to pursue his/her appeal before a panel of physicians and/or other providers selected by QualCare who have not previously 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 providers 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 provider(s) involved in the initial Utilization Management determination at issue shall not participate in 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 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 10 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 pre-service determinations regarding urgent or emergent care and 20 business days in the case of all other appeals.

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 about how the member and/or provider may arrange for an external review appeal and shall also include any forms required to initiate such an external appeal review.

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 review appeal process set forth below as Level III Appeal.

Level III External Appeal

To initiate a Level III External Appeal, a member and/or provider shall, within four months from receipt of the written documentation of the Level II Appeal, send a written request to:

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

The Utilization Management Appeals department will facilitate eligible external appeals through an Independent Review Organization (IRO). The IRO decision is communicated to the member.

Dispute Level	Provider/Practitioner Submission Timeframe	QualCare Response Timeframe	Contact Information
Level I	Appeal must be submitted within 180 calendar days.	Within five calendar days of receiving any additional information supporting the appeal.	Call: PPO: 800.992.6613 HMO/POS: 800.254.0130 Write: QualCare, Inc. Utilization Management Appeals Department 30 Knightsbridge Road Piscataway, N.J. 08854

Level II	Appeal must be submitted within 60 calendar days of the date of the Level I decision.	Within 20 business days of receiving any additional information supporting the appeal.	Call: PPO: 800.992.6613 HMO/POS: 800.254.0130 Write: QualCare, Inc. Utilization Management Appeals Department 30 Knightsbridge Road Piscataway, N.J. 08854
Level III	Appeal must be submitted within four months of the date of the Level II decision.	External Review Process: For Managed Care Plans follows state laws and regulations of the member's benefit plan.	For External Review, Write: QualCare, Inc. Utilization Management Appeals Department 30 Knightsbridge Road Piscataway, N.J. 08854

Quality Management

Medical Quality of Care Issues

A Medical Quality of Care (MQOC) issue is any incident of care which is a potential deviation from accepted standards of medical care on the part of a provider, which has caused damage to the patient.

Medical 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 immediately or 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.

The issue is then brought to the Credentialing Committee for a recommendation on network participation.

The UM 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 the 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.

The internal investigation will be concluded within 30 days of the receipt of the complaint. Extensions may be made, as needed, for thorough investigation and appropriate action and follow-up.

The member/provider is notified in writing of the resolution. Confidentiality is maintained throughout the process.

Types of Terminations and Range of Actions

Immediate Termination

Notification Requirement: Within 24 hours (one business day)

Right to Hearing: Yes

Immediate termination, without prior notice to provider will be considered when the following occurs, subject to provider contract limitations:

- Provider becomes incapable (impaired) of rendering services
- Provider's license or privilege to practice is revoked, restricted, or suspended by the applicable professional licensure board
- Provider's hospital privileges are revoked for cause
- Provider is disbarred, excluded, or suspended from Medicare/Medicaid
- Provider fails to maintain malpractice insurance as required
- Provider is convicted of a felony
- Provider's continuation may cause imminent danger to a patient or the public health, safety, or welfare, as determined by a QualCare medical director

Termination With or Without Cause

Notification Requirement: In accordance with the applicable contract (ex: 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 provider, allowing the provider an opportunity for peer review panel hearing. Reasons for such termination include, but are not limited to:

- Noncompliance with recredentialing requirements
- Medical Quality of Care issue(s) as determined by the Credentialing Committee
- Noncompliance with Utilization Management/Quality Assurance policies or requests for information
- Geographical necessity
- Network access
- Provider 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 provider
- Provider's hospital privileges are suspended or reduced

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 provider 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 30 days of receipt of the notice, as determined by the vice president of network management, NJ; however, a reoccurrence of the same or similar incident may result in termination.

Summary Suspension

Notification Requirement: 30 days

Right to Hearing: Yes

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

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:

- Provider receives a member complaint for physical appearance and accessibility of provider's office
- Provider receives a complaint or adverse issue, which includes adequacy of medical treatment and/or recordkeeping
- Provider has a corrective action plan due to a complaint or adverse issue for patient safety

Provider will be sent a letter that requests proof that the issue has been corrected. This may include a medical record audit, a letter stating changes to office policy or staff, or new office forms. If the proof is not sufficient then a corrective action plan will be shared with the provider.

Denial of Initial Application

Notification Requirement: 30 days from receipt of action notification

Right to Hearing: Yes

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

Denial of Recredentialing Application

Notification Requirement: 30 days from receipt of action notification

Right to Hearing: Yes

The provider's recredentialing application is denied when there is an issue with the application. Letters are sent to the provider for review and to correct any misinformation or document discrepancies. Notification will be sent to the licensure board and NPDB for immediate termination 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 the attention of the credentialing manager at QualCare, Inc. 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.

The following will occur upon receipt of a written request for a hearing:

1. The medical director contacts the appropriate panel members to schedule the hearing.
2. The associate vice president of Provider Operations or designee will contact the provider with the scheduled date of the hearing.
3. Minutes will be taken during the 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 also choose to have legal representation at the hearing. Each party may present witnesses and question the other party's witnesses.
5. The provider will be notified via certified mail within 30 business days of panel's decision unless the panel provides written notice within that 30-day period that it needs an extension.
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:
    - 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.
    - The panel's recommendation for corrective action, termination, provisional reinstatement, or reinstatement.
    - The panel shall state the reason for its recommendation, including the reasons for any provisional reinstatement.
    - 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:

- Three network providers, at least one of whom is a clinical peer in the same discipline and the same or similar specialty as the provider requesting the hearing.
- Designated Cigna legal support for QualCare care management (optional).

Benefit/Administrative Appeal Process

- Provider appeals must be submitted in writing. 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 for all denial letters.
- Level I member appeals may be submitted verbally. Level II appeals must be submitted in writing. A written response will follow, including a recitation of the issue, the resolution and rationale documented in Uniflow. If the appeal is not resolved to the satisfaction of the member, QualCare will provide the member with a written explanation of their right to proceed to a Level II Appeal.
- The timeframe allotted for timely filing of appeal submissions is based upon the client communication package. Standard guidelines apply for the timely filing of claims submissions.
- Providers may appeal on behalf of a member; however, an authorized release form must be signed by the member turning over all appeal rights to the provider.

Important Terms and Definitions

Carrier: 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.

Clean claim: 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 qualcareinc.com. Click on "Provider" and review our "Documents and Forms" page.

Coinsurance: 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.

Coordination of benefits: Also referred to as "COB," these are 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.

Copayment: 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.

Covered services: Medically necessary services and supplies that a member is entitled to receive coverage for as described under a health benefits plan. Services that are not medically necessary shall not be deemed covered services for purposes of this agreement or the health benefits plan.

Deductible: The amount a member pays out-of-pocket each year before the health benefits plan begins to pay for services provided.

Emergency: 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 possesses 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 and/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 and/or unborn child. Emergency services include a medical screening examination and inpatient and outpatient services that are needed to stabilize an emergency medical condition.

Fully insured: An employer pays a fixed monthly premium to a health insurance company to take financial risk for their claims and provide and administer benefit 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.

Health benefits plan: Also referred to as a "plan," it is 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.

Hospital services: Those inpatient, emergency, outpatient, or other health care facility services that are generally and customarily provided to patients by or through a hospital or its affiliated health care facilities.

Material: A change that QualCare determines could reasonably be expected to have a substantial adverse impact on provider's reimbursement for covered services hereunder.

Medically necessary: The use of services and/or supplies as determined by the Utilization Management and Quality Assurance programs that: a) are consistent with the symptoms or diagnosis and treatment of a member's condition, disease, ailment, or injury or are preventative covered services; b) are in accordance with approved and generally accepted medical or surgical practice; c) are not solely for the convenience of a member or health care provider; and d) 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. This definition may change based upon the underlying health benefit plan.

Member: 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.

Participating hospital: 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.

Participating physician: A physician or provider 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.

Participating provider: 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.

Payor: 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.

Physician services: Health care services that can be provided by a duly licensed physician or provider as part of the physician's or provider's legally permitted practice.

Primary care provider: Also referred to as a PCP, this is an individual participating provider who supervises, coordinates, and provides initial and basic care to members, and maintains continuity of care for members.

Primary care services: Those covered services determined to be primary care services by QualCare, and/or the applicable payor.

Provider: 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.

Quality management: Also known as QM, this is the process of measuring, evaluating, and improving the provision of quality medical services, procedures, and facilities to members.

Referral: 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.

Self-funded health plan: 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 explanation of benefits (EOB). The self-funded employer group is responsible for transferring the funds for claim payments 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 Employee Retirement Income Security Act of 1974 and federal law.

Specialist physician: 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.

Urgently needed services: 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 24 hours.

Utilization Management: Also referred to as UM, it is a system for reviewing the appropriate coverage 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 under the health benefits plan. The system may include preadmission certification, the application of practice or

coverage guidelines, continued-stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.