PROVIDER MANUAL

QualCare
Spring 2023

QUALCARE®

Welcome to QualCare

The primary objective of QualCare is to offer clients and members access to high-quality medical care in a cost-effective environment. Our success depends on your support.

QualCare offers insurance carriers and third-party administrators access to our provider network. The QualCare network includes health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO) and workers' compensation (WC) networks.

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

Our network includes more than 86,000 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. Go to QualCareInc.com > My QualCare > Find a Doctor. To make updates, please notify QualCare Provider Relations.

We are committed to ensuring that your participation in the QualCare network is a positive and beneficial experience. Please call QualCare Provider Relations **800.992.6613** if you have any questions or concerns.

Thank you for the quality care you provide to our members. We look forward to working with you.

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Quick Reference Contact Information

Corporate Mailing Address

QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854

Corporate Main Number

800.992.6613

Provider Relations

Our provider Relations staff is available to assist with:

- Training office staff
- Claims review
- Contract Inquiries
- Compliance and Education
- Demographic maintenance

800.992.6613

Claims Address

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

Directory of Participating Providers

QualCare comprehensive provider network ensures members will have their medical needs met in a continuous and coordinated manner by skilled physicians, quality ancillary providers, and well-established hospitals.

The QualCare provider directory lists all network-participating providers by specialty, county, and city. It is available online at QualCareinc.com > My QualCare > Find a Doctor.

Eligibility Information

You can verify the eligibility of active members and check claim status by calling the telephone number on the back of your patient's member ID card.

Member Services

If you have questions about benefits, policies, and procedures, call the telephone number listed on the back of your patient's member ID card.

The QualCare Network

History and Overview

QualCare was founded in 1991 as a PPO by SSM Health Care Ministry Corporation and St. Clare's Physician Organization, Inc. It was called Preferred Providers of New Jersey, Inc. (PPNJ), 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 their dependents. In 1994, the company expanded its customer base to include small and medium-size self-insured employer groups and expanded the hospital and provider network to include non-sponsored hospitals and providers. In 1995, PPNJ was liquidated, and the sponsors incorporated QualCare as a New Jersey for-profit corporation. QualCare Alliance Networks, Inc. (QANI) was founded to serve as the parent organization to QualCare, Inc. and Qual-Lynx.

In 2010, QANI expanded their Property & Casualty and Workers' Compensation third party administrative services through the acquisition of Scibal Associates.

QANI was acquired in 2015 by Connecticut-based Cigna Corporation. QualCare and Qual-Lynx continued to offer best-in-class Health and Workers' Compensation services.

In July 2021, QualCare became part of the Enlyte family of companies, and continues to make affordable, quality health care available to carriers who want a comprehensive network of exceptional providers.

Our Agreement

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

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, which you should always refer to when you have a question.

The respective commitments of QualCare and participating providers are highlighted below.

The QualCare Commitment

- We will strive to balance the need for equitable reimbursement for participating providers.
- We will work to give the best service possible to participating providers. We value your relationship and recognize it is key to our continued success.

Participating Providers' Commitment

- See and treat QualCare members within the prescribed access standards, and with the same regard and diligence as for 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 client cost-containment programs.

Provider Credentialing and Recredentialing

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

Credentialing Process

QualCare stipulates mandatory credentialing of all licensed health care providers prior to participation in the QualCare network.

QualCare adheres to National Committee of Quality Assurance (NCQA) standards, N.J.A.C.11:24A-4.7, N.J.A.C. 11:24-3.9 for credentialing providers. Additionally:

- Credentialing and recredentialing policies and procedures are adopted by the Credentialing 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. As part of the completed application, the provider must include:
    - Application/recredentialing application, signed and dated.
    - Education and training.
    - Work history/resume, including start and end dates, and an explanation of any gaps longer than six months.
    - Licensure: Legible copy of unrestricted current New Jersey state license and all other applicable state licenses.
    - Drug Enforcement Agency (DEA) registration: Legible, current copy.
    - Controlled Dangerous Substance (CDS) registration: Legible, current copy of certificate.
    - Malpractice coverage: Legible copy of current malpractice face sheet with coverage of $1 million per occurrence and $3 million aggregate.
    - Board certification (if applicable): Legible, current copy.
    - Hospital privileges, including primary admitting hospital and all other admitting hospitals, if applicable. Hospital privileges must be at a QualCare-participating hospital.
    - Disclosure questions: Accurate and full answers to the questions regarding malpractice history, ability to perform functions, history of any license loss and felony convictions, history of loss or limitations of any privileges, and history/disclosure of substance abuse or addiction problems.
    - Statement of collaboration: Required for all nurse practitioners, physician assistants, and nurse midwives.

QualCare Credentialing performs all primary source verification on the above-required documents, including sanctions and malpractice history, as needed, through national databases approved by NCQA.

Required documents must be no older than 180 days.

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

All information obtained for credentialing purposes will be kept confidential. The applicant may review it, 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 will be reviewed by the Credentialing Committee, which comprises staff and non-staff physicians, and the files accepted, denied, or tabled for additional information. The tabled files will be updated before being presented at the next Credentialing Committee meeting. Denied applicants may reapply in 12 months.

Credentialing will notify all providers of their acceptance or denial into the QualCare network within 60 days of the Credentialing Committee's decision. Providers have the right to appeal or request reconsideration through written notification.

Recredentialing Process

All providers are re-credentialed every three years from the date of their initial acceptance into the QualCare network. A provider's continued participation will depend on the 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 who are 100 percent hospital based. Examples include emergency medicine providers, radiologists, pathologists, anesthesiologists, and other specialists who are 100 percent hospital based.

Recredentialing follows the same procedure as the credentialing process, as documented in the previous section.

Benefit Coverage

Please contact the applicable network access carrier (Oscar, Emblem Health, or Humana) to determine which services and items are covered.

Sample ID Cards

Please note: These are sample ID cards only. Any valid Oscar, Emblem Health, or Humana ID card should be accepted.

Oscar

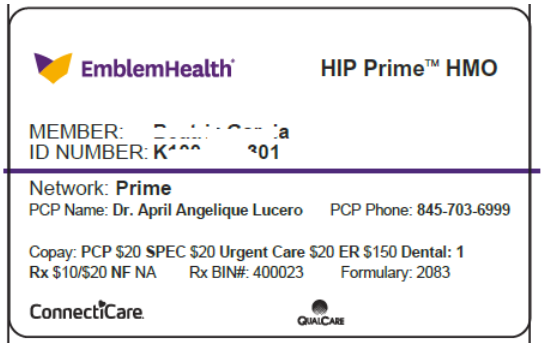
Member ID Cards

All Oscar members receive and should present to you a member Identification Card (ID). The following information can be found on the most common Oscar ID Cards:

Oscar Member ID Card - Front

Oscar Member ID Card - Back

Emblem Health

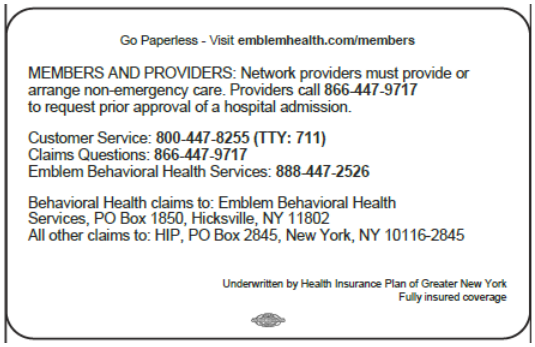

EmblemHealth HIP Prime™ HMO

MEMBER: [redacted]a
ID NUMBER: K[redacted]301

Network: Prime
PCP Name: Dr. April Angelique Lucero PCP Phone: 845-703-6999

Copay: PCP $20 SPEC $20 Urgent Care $20 ER $150 Dental: 1
Rx $10/$20 NF NA Rx BIN#: 400023 Formulary: 2083

ConnectiCare QUALCARE


Go Paperless - Visit emblemhealth.com/members

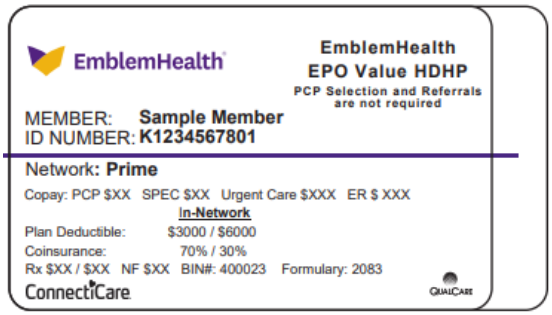
MEMBERS AND PROVIDERS: Network providers must provide or arrange non-emergency care. Providers call 866-447-9717 to request prior approval of a hospital admission.

Customer Service: 800-447-8255 (TTY: 711)
Claims Questions: 866-447-9717
Emblem Behavioral Health Services: 888-447-2526

Behavioral Health claims to: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802
All other claims to: HIP, PO Box 2845, New York, NY 10116-2845

Underwritten by Health Insurance Plan of Greater New York
Fully insured coverage

EPO Value HDHP


EmblemHealth
EmblemHealth EPO Value HDHP
PCP Selection and Referrals are not required

MEMBER: Sample Member
ID NUMBER: K1234567801

Network: Prime
Copy: PCP $XX SPEC $XX Urgent Care $XXX ER $ XXX
In-Network
Plan Deductible: $3000 / $6000
Coinsurance: 70% / 30%
Rx $XX / $XX NF $XX BIN#: 400023 Formulary: 2083

ConnectiCare QUALCARE


Go Paperless - Visit emblemhealth.com/members

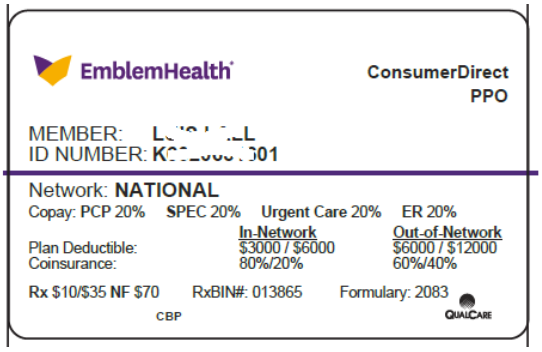
MEMBERS AND PROVIDERS: Network providers must provide or arrange nonemergency care. Providers call 1-866-447-9717, option 3 to request prior approval of a hospital admission.

Customer Service: 1-800-447-8255 (TTY/TDD: 711)
Claims Questions: 1-866-447-9717
Emblem Behavioral Health Services: 1-888-447-2526

Behavioral Health claims to: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802
All other claims to: EmblemHealth, PO Box 2845, New York, NY 10116-2845

First Health Network An Aetna subsidiary
Underwritten by EmblemHealth Insurance Company
This coverage is fully insured

PPO


EmblemHealth ConsumerDirect PPO

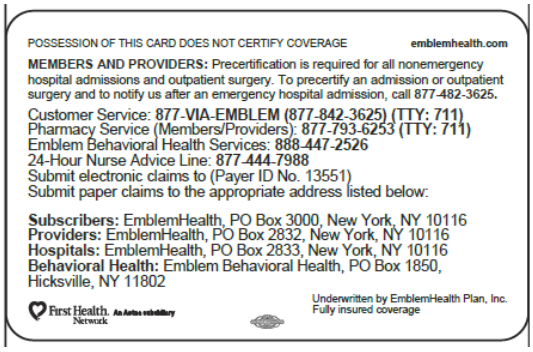
MEMBER: L[redacted]L
ID NUMBER: K[redacted]301

Network: NATIONAL
Copy: PCP 20% SPEC 20% Urgent Care 20% ER 20%

	In-Network	Out-of-Network
Plan Deductible:	$3000 / $6000	$6000 / $12000
Coinsurance:	80%/20%	60%/40%

Rx $10/$35 NF $70 RxBIN#: 013865 Formulary: 2083

CBP QUALCARE


POSSESSION OF THIS CARD DOES NOT CERTIFY COVERAGE emblemhealth.com

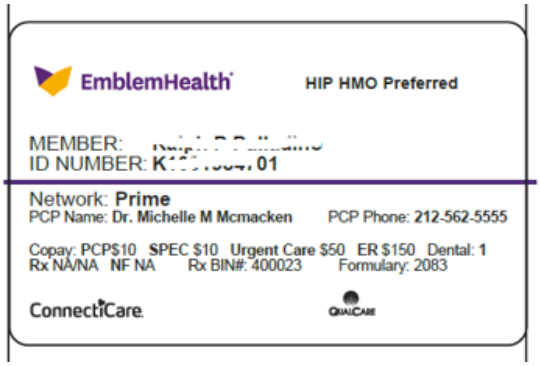
MEMBERS AND PROVIDERS: Precertification is required for all nonemergency hospital admissions and outpatient surgery. To precertify an admission or outpatient surgery and to notify us after an emergency hospital admission, call 877-482-3625.

Customer Service: 877-VIA-EMBLEM (877-842-3625) (TTY: 711)
Pharmacy Service (Members/Providers): 877-793-6253 (TTY: 711)
Emblem Behavioral Health Services: 888-447-2526
24-Hour Nurse Advice Line: 877-444-7988
Submit electronic claims to (Payer ID No. 13551)
Submit paper claims to the appropriate address listed below:

Subscribers: EmblemHealth, PO Box 3000, New York, NY 10116
Providers: EmblemHealth, PO Box 2832, New York, NY 10116
Hospitals: EmblemHealth, PO Box 2833, New York, NY 10116
Behavioral Health: Emblem Behavioral Health, PO Box 1850, Hicksville, NY 11802

First Health Network An Aetna subsidiary
Underwritten by EmblemHealth Plan, Inc.
Fully insured coverage

HMO

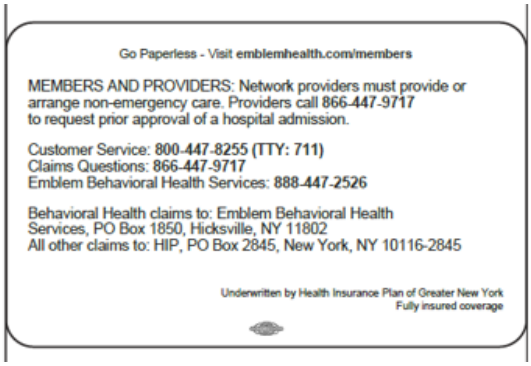

EmblemHealth HIP HMO Preferred

MEMBER: [redacted]
ID NUMBER: K[redacted]01

Network: Prime
PCP Name: Dr. Michelle M Mcmacken PCP Phone: 212-562-5555

Copay: PCP$10 SPEC $10 Urgent Care $50 ER $150 Dental: 1
Rx NA/NA NF NA Rx BIN#: 400023 Formulary: 2083

ConnectiCare QUALCARE


Go Paperless - Visit emblemhealth.com/members

MEMBERS AND PROVIDERS: Network providers must provide or arrange non-emergency care. Providers call 866-447-9717 to request prior approval of a hospital admission.

Customer Service: 800-447-8255 (TTY: 711)
Claims Questions: 866-447-9717
Emblem Behavioral Health Services: 888-447-2526

Behavioral Health claims to: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802
All other claims to: HIP, PO Box 2845, New York, NY 10116-2845

Underwritten by Health Insurance Plan of Greater New York
Fully insured coverage

Humana

Members Without an ID Card

While members are advised to always present their ID card when receiving services, there may be instances when an ID card is not available at the time of service.

You can obtain benefits, eligibility, and current contact information by communicating with the member's plan directly at the websites below. You may also be able to check member eligibility through a secured online portal, interactive voice response system, 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 Provider Relations in writing if practice information changes, such as:

- Name
- Address
- Telephone number
- State license
- Providers in the group
- Office hours
- Panel closing
- Taxpayer Identification Number (TIN)
- Covering provider arrangements
- Billing address
- Reduction in services
- Admitting privileges

Written notices should be sent to:
QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 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

Role

Primary care providers (PCPs) are responsible for helping to manage the health care of assigned members. We reimburse network-participating PCPs 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, 365 days a year.

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 to network-participating providers and hospitals.
- Provide information to and cooperate with QualCare to facilitate coverage decisions.

Referrals

As part of your contract with QualCare, you agree to refer your patients with QualCare coverage to network-participating physicians, hospitals, and other providers and facilities to help them maximize their benefits. (There may be exceptions such as emergencies, or if services cannot be provided within the network.) Otherwise, when you refer members to nonparticipating providers, they may incur unexpected financial liabilities.

Specialists

Role

When required, they must have a referral from the referring PCP when the member has an HMO or POS plan. The exception is gynecological and obstetrical services, which require no precertification or referral. The specialist and PCP should work together to coordinate the best care for the member.

Responsibilities

Specialists are responsible for:

- Verifying that precertification has been obtained before rendering services, if required. If services are rendered without required precertification, claims may be denied, and the member should not be billed.
- Verifying a member's eligibility before rendering services.
- Providing a designated PCP with follow-up information when a PCP is identified.

Referrals

As part of your contract with QualCare, you agree to refer your patients with access to the QualCare Network to QualCare Network participating physicians, hospitals, and other providers and facilities to help them maximize their benefits. (There may be exceptions such as emergencies, or if services cannot be provided within the network.) Otherwise, when you refer members to nonparticipating providers, they may incur unexpected financial liabilities.

Advance Directives

QualCare HMO Network-Participating Providers

Providers who participate in the QualCare HMO network are required to give information about advance directives to their patients.

An advance directive can help providers identify someone authorized by the patient to make decisions on the patient's behalf in a crisis. It may also allow providers and family members to make decisions for treatment based on the patient's wishes if the patient is no longer able to do so.

Your patients can obtain a health care proxy form (a type of advance directive form) from a number of sources, such as certain social service agencies and the New Jersey Department of Health website (NJ.gov/health) > Offices & Programs > Consumer Health > Department: Topic A to Z > Advance Directives (Living Wills) > Advance Directive > Forms & 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. Network-participating providers have agreed to meet the provider availability and access standards below.

Type	Access Standard
Emergency	Immediate access 24 hours a day, 365 days a year
Urgent	24 hours or less
Routine	2 weeks or less
Preventive Physical Exams	4 months or less

Network-participating providers are responsible for ensuring coverage 24 hours a day, 365 days a year. If you enter a coverage arrangement with another provider, you are responsible for ensuring the covering provider abides by all terms and conditions of your QualCare Provider Agreement, including acceptance of the 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 to render services to eligible members agrees to accept the fee reimbursement stated in the QualCare Provider Agreement as full payment, less any applicable copayments, coinsurance, and deductible amounts.

Copayments

A copayment is the dollar amount a member must pay for a specific health service such as an office visit, outpatient prescription, or emergency room visit. The member's ID card will show the required copayment amount, as well as the Member Services telephone number to call for copayment verification.

The provider is responsible for collecting the copayment at the time of service and showing the collected amount on the claim form.

Billing Members

Covered Services

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 except for copayments, coinsurance, and deductibles, which the provider is responsible for collecting.

Not Covered Services

For services not covered, the provider may bill the member directly if:

- The provider has informed the member prior to rendering the service that the service is not covered, and the member will be responsible for payment.
- The member nonetheless requests 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 the provider explains to the member, prior to rendering services, that the member would be financially responsible for the services.

If you have questions about billing members, call. the number on the back of the members Identification Card

Claim 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 National Electronic Information Clearinghouse (NEIC) payor IDs, which are listed below, can also be found on the back of a member's ID card.

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

If you choose to submit a paper claim, you must complete Form CMS-1500 or its equivalent in its entirety. Please indicate any copayment 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 covered services as previously described in this manual. You must submit encounter information for all visits, including those for which no billable services were provided, in accordance with network-access guidelines.

- hioscar.com/providers/resources
- Emblemhealth.com/providers
- Humana.com/provider/

Group Health Claim Cycle

Office Visit Versus Consultation

According to the current edition of the American Medical Association 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.”

Providers must document the request for a consultation in the patient’s medical record and communicate the consultant’s opinion to the requesting provider. When you see a patient for consultation (as defined above), use Current Procedural Terminology (CPT) codes in the 99241-99245 series.

Coding Preventive Services

Correctly coding preventive care services is essential to receive accurate payment. Submit preventive care services with International Classification of Diseases, 10th Revision (ICD-10) codes that represent encounters that are not for the treatment of illness or injury.

- Place the ICD-10 code in the first diagnosis position on the claim form.
- If you place a diagnosis code that represents treatment of an illness or an injury in the first diagnosis position on the claim form, the claim will be paid, as applicable, under normal medical benefits rather than under preventive care benefits.
- If you incorrectly code a non-preventive care service as “Preventive Medicine Evaluation and Management Services,” it will not be covered as a preventive care benefit.

Annual Gynecological Exam and Pap Test & Newborn Care

Questions surrounding preventive care should be directed to the member plan:

  - Please contact the plan using the number on the back of the members Identification Card
- hioscar.com/providers/resources
- EmblemHealth.com/providers
- Humana.com/provider/

Referrals (HMO and POS plans)

  - Please contact the plan using the number on the back of the members Identification Card
- hioscar.com/providers/resources
- EmblemHealth.com/providers
- Humana.com/provider/

Submitting Claims

For a claim form to be considered complete and processed as quickly as possible, it must include all of the information below. Otherwise, it will be returned with a request for the appropriate information.

Member Information

- Name, member ID number from ID card, date of birth, sex, and address.
- Health benefit plan, employer identification number, and group name and number, if indicated.
- Other insurance or coverage, including a copy of the primary payor's explanation of benefits (EOB), if applicable.
- If care is provided as the result of an accident, indicate location, date, and type of accident.

Provider or Supplier Information

- Name of the provider who referred the patient, if applicable
- Diagnostic code and brief description. If an ICD-10 code is not available, give a detailed description of the service/procedure performed.
- Date(s) of service
- Place of service
- CPT Fourth Edition (CPT-4) codes, along with modifiers when appropriate (If CPT-4 codes are not available, use the appropriate codes and give a detailed description of the service or procedure performed.)
- Provider's customary charge for each procedure listed, along with the total charges for the claim, including any copayments received.
- Specific amount of time for the service if billing for anesthesiology or other time-related services
- TIN or Social Security number of the provider performing the services.
- National Provider Identifier (NPI) of the provider performing the services.
- Name, signature, and address of the provider performing the services.
- Referral form (attach) for specialist visits, as required by applicable HMO and POS plans.

Where to Send Claims

Send claims to the address listed on the back of the member's ID card, which may vary from patient to patient. This will help ensure timely and accurate claims processing.

Time Limit for Claim Submission

The provider must submit an accurate and complete claim within 180 days of the date of service or discharge. Failure to do so will result in forfeiture of all rights to bill the payor or member for such services.

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

Claim Payment

Under circumstances that require coordination of benefits or a claim review process, 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 and indicate and explain any disallowances or denials. If you have questions regarding payment or need more specific information

related to denials or disallowances, either call the telephone number on the voucher or the telephone number for Member Services on the member's ID card. For additional assistance, call QualCare Provider Relations at **800.992.6613**.

Claims Review Procedure

If a claim has been denied, in whole or in part, the provider may dispute the denial. See the Provider Complaints Procedure section of this manual for information about how to file a dispute or complaint.

Ancillary Services

Certain ancillary services are subject to the guidelines outlined below, 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, the member should not be billed for a copayment or an office visit.

The provider may draw and collect specimens in the office and send them to a participating lab for testing, or the provider may refer a member directly to a participating lab's draw station. When making a referral to a draw station, write a lab slip that contains complete insurance information, including the health benefit plan, employer group, plan group number, and member ID.

Billable Lab Services

Please refer to the websites below for information about billable lab services.

- hioscar.com/providers/resources
- EmblemHealth.com/providers
- Humana.com/provider/

Radiology

Please refer to the websites below for information about radiology services.

- hioscar.com/providers/resources
- EmblemHealth.com/providers
- Humana.com/provider/

Prescription Benefits

Please refer to the websites below for information about prescription benefits.

- hioscar.com/providers/resources
- Emblemhealth.com/providers
- Humana.com/provider/

Mental Health and Substance Abuse Services

Please refer to the websites below for information about mental health and substance abuse services.

- hioscar.com/providers/resources
- EmblemHealth.com/providers
- Humana.com/provider/

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that covers health plans, providers, and clearinghouses. The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing various provisions of this law.

Administrative Simplification Act Overview

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. It also establishes standards for the privacy of individually identifiable health information. *

Transactions and Code Sets Overview

As of October 16, 2003, entities covered by HIPAA are required to process electronic transactions in HIPAA-compliant formats. 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 HIPAA electronic transactions and code set standards (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.”

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.

EDI can eliminate the inefficiencies of handling paper documents, reduce administrative burden, lower operating costs, and improve overall data quality.** For detailed information about HIPAA, visit CMS.gov > Regulations & Guidance > Administrative Simplification: HIPAA and ACA.

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 privacy regulations require the addition of, or change to, numerous administrative processes at a health care organization. Entities covered by HIPAA 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.

Security Overview

The security standards work in concert with the final privacy standards adopted by the U.S. Department of Health & Human Services (HHS). The two sets of standards use many of the same terms and definitions to make it easier for covered entities to comply. The final HIPAA security standards 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, 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 in the health care delivery system. The final National Employer Identifier Rule compliance date was July 30, 2004. The National Employer ID uses the Internal Revenue Service (IRS) Employer Identification Number (EIN) for this unique identifier.

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.
- Policies and procedures that address the release of patient information to any internal and external person. Each office must have a copy of the policy.

A member's medical record must be maintained in a current, detailed, organized manner that permits effective patient care and facilitates quality review. It is a legal document, and its contents are confidential.

The policy objective is to ensure the:

- Care rendered to members is consistently documented, and this documentation is high quality and contains all the information necessary to always make medical determinations readily available.
- The medical record is complete and includes all the elements of a member's health history, treatment rendered, and response to the treatment.
- Effective transfer of care between the PCP and the specialty provider, in the interest of excellence in member care, and to enhance service between providers.
- 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.

Organization

Each member's medical record must:

- Be individually trackable.
- Be secured to maintain confidentiality.
- Contains a section for patient identification that includes name, age, gender, employer, occupation, work and home telephone numbers, insurance information, and marital status.
- Include the member's name or ID number on every page.
- Contain legible author identification that is dated for every entry.

Documentation

You must document the member's medical record to include:

- Medication allergies and adverse reactions: Note in a consistent, prominent place.
- Past medical history (including use of cigarettes, alcohol, and substance use) for members who your practice has seen two or more times.
- Problem lists for members with significant illnesses or conditions that should be monitored. Include a chief complaint, as well as a diagnosis or probable diagnosis.
- Documentation of an exam appropriate for the condition.
- All medications prescribed: Note the name, dosage, frequency, and duration.
- Medications given onsite: Note the name, dosage, route, site where given, and batch number.
- Treatments, procedures, tests, and results.
- Member education, recommendation, and instructions given.
- Completed immunization record or an up-to-date notation of immunizations.

Completeness

To ensure the timeliness and completeness of a medical record:

- Check the medical record in the appropriate time frame to ensure all ordered procedures and referrals have been returned and filed in the chart.
- Be sure 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 delivery and service are included in the provider's quality profile for use at the time of recredentialing.

Information regarding medical record guidelines and standards is given to providers at the time of their network-participation approval, and at the time of any medical record guideline revision.

Provider Complaints Procedure

Delivery Methods

Providers may register complaints by calling Provider Relations or sending a written complaint via fax, email, or U.S. mail.

Fax:
732.562.7868
Attn: Provider Relations

Email:
QCProvRel@QualCareinc.com

Mail:
QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854
Attn: Provider Relations

Information You Will Need to Share

When registering a complaint, you will need to share:

- Providers contact information, including address, telephone number, and fax number.
- Your office contact person's name and title.
- Your TIN.
- Clear description of the complaint.
- Preferred contact times for follow up with your office.

QualCare is dedicated to resolving provider complaints promptly whenever possible. Generally, we will respond in the same manner that we received the complaint – by telephone or in writing.

Utilization Management Process

Call the telephone number listed on the back of your patient's member ID card for utilization management inquiries or access this information from the appropriate carrier's website.

- hioscar.com/providers/resources
- EmblemHealth.com/providers
- Humana.com/provider/

Quality Management

Medical Quality of Care Issues

Members will call the number listed on the back of their member ID card for medical quality of care inquiries.

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 a provider will be considered, subject to contract limitations, when the provider:

- Becomes incapable (impaired) of rendering services.
- Has license or privilege to practice revoked, restricted, or suspended by the applicable professional licensure board.
- Has hospital privileges revoked for cause.
- Is disbarred, excluded, or suspended from Medicare/Medicaid.
- Fails to maintain malpractice insurance as required.
- Is convicted of a felony.
- May cause imminent danger to a patient or to 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 (e.g., 90 or 120 days)
Right to hearing: Yes.

Termination, with or without cause, may be made at any time with at least 90 days' notice to the provider, to allow the provider an opportunity for a 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 or quality assurance policies or requests for information.
- Geographical necessity.
- Network access.
- Provider being placed on probation, reprimanded, or fined, or having privileges restricted by the applicable professional licensure board.
- Determination of fraud on the part of the provider.
- Suspension or reduction of a provider's hospital privileges.

Material Breach Termination

Notification requirement: 30 days.
Right to hearing: No.

Termination due to a material breach of the QualCare Physician Agreement may be made with at least 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 QualCare 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 the 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 we receive proof of correction of the issue or there is a resolution by the licensure board, courts, or QualCare. We will notify the licensure board and National Practitioner Data Bank for immediate terminations as approved by the QualCare 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 provider:

- Receives a member complaint for physical appearance (facility or staff) and accessibility of the provider's office.
- Receives a complaint or adverse issue, which includes adequacy of medical treatment recordkeeping, or patient safety.

We will send the provider a letter requesting proof that we have corrected the issue. This may include a medical record audit, a letter outlining changes to office policy or staff, or new office forms. If the proof is not sufficient, we will share a corrective action plan 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 will be denied when there is an issue with the application. We will send the provider a letter requesting the correction of 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 will be denied when there is an issue with the application. We will send the provider a letter requesting the correction of any misinformation or document discrepancies.

We will also notify the licensure board and National Practitioner Data Bank of immediate termination as approved by the Quality Management Committee.

The Appeal Process

The appeal process will be initiated when we receive a provider's written request for an appeal hearing. The provider must send the request to QualCare Credentialing. This request must be received within 30 days of the certified termination notification letter for prospective terminations, and within 48 hours for immediate terminations. The termination notice will include the appropriate contact information for filing an appeal.

When we receive a written request for a hearing:

- A QualCare Medical Director will contact the appropriate panel members to schedule the hearing.
- The QualCare Associate Vice President of Provider Operations or a designee will contact the provider with the scheduled date of the hearing.
- Minutes will be taken during the hearing.
- The provider will be given the right to address the action verbally and submit documentation to support the appeal.
- The provider will have the right to bring legal counsel to the hearing, and QualCare may also have legal representation. Each party may present witnesses and question the other party's witnesses.
- The provider will be notified via certified mail within 30 business days of the panel's decision, unless the panel provides written notice within that 30-day period that it needs an extension.
- All documentation obtained during the hearing process will be kept confidential.

The information documented in the panel's decision will include:

- The relevant contract provisions, and the facts from the hearing on which the panel relied 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.
- Reason for the recommendation and any provisional reinstatement, if applicable.
- Specific conditions for reinstatement, if applicable, as well as the duration of the conditions, consequences of a failure to meet the conditions, and impact it may have on the terms and conditions of the contract at issue.

The hearing will be conducted by:

- Three network providers, with at least one being 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

Please refer to the websites below for information about Benefit/Administrative Appeal Process

- hioscar.com/providers/resources
- EmblemHealth.com/providers
- Humana.com/provider/

Workers' Compensation Providers

QualCare, the largest workers' compensation provider network in New Jersey, offers industry-leading medical care and cost-containment solutions to workers' compensation clients.

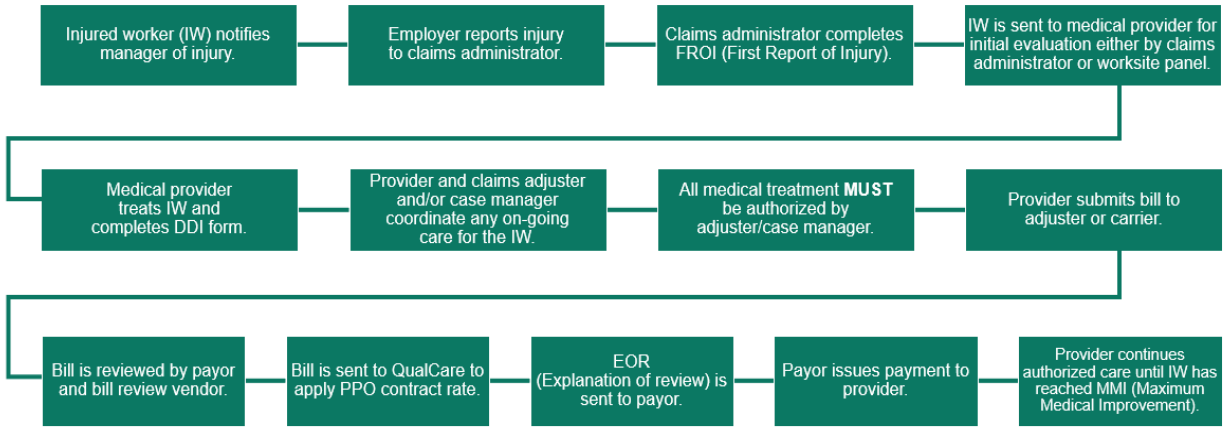
Workers' Compensation clients we serve:

- **Third Party Administrators (TPAs)**
    - Manage the claim process for self-insured entities, joint insurance funds (JIFs) and insurance pools.
- **Network Access**
    - Serves as the New Jersey workers' compensation network solution for national insurance carriers.

Treating Workers' Compensation claimants vs. Group Health patients

Workers' Compensation	Group Health
Every aspect of an injured worker's care falls under a single claim; unlike group health, a claim is an episode of injury, not an individual bill.	Claim goes to insurance for payment for medical care provided.
No patient contribution (co-pays, coinsurance, deductibles, caps) because the payor pays the bill.	Provider & patient Explanation of Benefits (EOB).
Covers medical care and indemnity costs while unable to work.	Providers collect additional amounts from other parties.
Provider receives Explanation of Review (EOR).	Cost sharing model (deductibles, co-pays, and coinsurance.)
Focused on medical treatment and return-to-work guidelines and timelines as specified by the state.	Unconcerned with state medical treatment guidelines.
Payor owns claim until closes, settled, and /or maximum medical improvement is reached.	Covers treatment delivered during individual eligibility.

Cycle of an Injured Worker



- To help support the network, QualCare offers workers' compensation payors and employers access to online directories and worksite posters. Use the Find a Provider tool at **www.qualcareinc.com** to identify participating network providers.

What to expect: Initial interaction

Your office will be contacted by either the employer group, claims handler, case manager, or clinical coordinator to:

- Schedule an appointment for a claimant, or
- Alert you that a claimant will be coming to your office (walk-in facilities only).

At the time of initial contact, the applicable carrier will provide you with additional information regarding required prior authorizations, precertification's, and medical documentation necessary to treat the occupationally injured claimant. If an injured worker visits your office without advanced contact, please gather the appropriate information from the claimant and ask his or her employer who you should contact to obtain billing information and begin the case management process.

You must make:

- Primary, urgent, or occupational care available immediately.
- Specialist appointments available within 72 hours of the request.

Workers' compensation contact information

You may contact us 24 hours a day, 365 days a year.

P: 800.425.3222

F: 732.562.2815

Authorization to treat claimant: Quick Note form

Prior to each medical encounter, a quick note form and precertification letter will be sent to your office, which together will act as authorization to treat the claimant.

The quick note form is used to quickly gather the medical diagnosis, treatment, and work status information, and share it with employers and claims adjusters. You will receive claimant information, such as the name, date of injury, date of visit, body part, precertification number, claim number, and service authorized.

After evaluating the claimant, you must complete the appropriate sections of the form, paying particular attention to the:

- Diagnosis codes and International Classification of Diseases, 10th Revision (ICD-10) codes.
- Causal relationship to the injury or illness.
- Treatment plan.
- Level of function.
- Date of return visit (if applicable).
- Request for specialist referral (which must be preauthorized by claims handler or nurse case manager).
- Anticipated discharge date (when appropriate).
- Current work status or any work restrictions (to be sent within 24 hours).

Case managers and claims adjusters work with contracted employer groups to identify alternate duty assignments for claimants during the treatment period. Therefore, you are required to evaluate claimants in terms of functional capacity, and provide specific information in the areas of lifting, standing, walking, sitting, driving, use of hands and arms, bending, twisting, climbing, and reaching.

Medical notes

Within seven to ten days following an office visit, you must provide the case manager or claims adjuster with typed medical notes, including impressions, a recommended treatment plan, work status, anticipated date of maximum medical improvement, and return-to-work information.

Precertification of nonemergency services required.

Precertification is required for all nonemergency services, including (but not limited to):

- Diagnostic tests.
- Physical therapy.
- Occupational therapy.
- Surgery.
- Pain management procedures.
- Inpatient procedures.
- Durable medical equipment.
- Home health services.
- Specialist services.

Prescription medications related to an injury should be sent to the case manager or claims adjuster for approval. No physician-dispensed medications will be reimbursed.

Physical and occupational therapies

When ordering physical therapy or occupational therapy, you must include a prescription when you send the quick note to the case manager or claims adjuster.

Prior surgical authorizations

If a claimant needs nonemergency surgery, please clearly note this in the quick note. You will need to obtain authorization from the case manager or claims adjuster prior to the procedure date. **Please note:** All procedures must be performed at a hospital or facility in the QualCare provider network.

You must complete the form in its entirety, which may include:

- Diagnosis.
- Name of the surgical procedure.
- Anticipated Current Procedural Terminology (CPT®) codes, as well as ICD-10 codes and modifiers to be billed.
- Date of the surgery.
- Date of pre-admission tests (PATs).
- Surgery location.
- Admission type: Inpatient (and length of stay) *or* Ambulatory (same day).
- Projected return-to-work date.
- Request for assistant surgeon (*assistant surgeons and co-surgeons will not be approved without precertification).*

Specialist referrals

If you determine the claimant needs a referral for additional medical services, you must advise the case manager or the claims adjuster handling the initial referral. An appropriate network-participating provider or facility will be identified to meet the referral need, and a case manager or claims adjuster will make all arrangements related to appointments. **Referrals made directly to providers that do not participate in the QualCare network will not be covered.**

Patient copayments

There are no copayments of any kind for care received under workers' compensation programs. The payments you receive from workers' compensation payors constitute payment in full for the services rendered.

Furthermore, **New Jersey law** prohibits you from billing your patients for services rendered for workers' compensation claims. This means it is against the law to bill patients for any dollar amount, including the balance between actual charges and the allowable amount.

Claim submissions

To expedite processing of workers' compensation bills, please use either the claim or authorization number claims adjuster or case manager when the patient's initial visit was scheduled. The quick note form must be submitted within 24 hours of the visit.

Electronic bill submission required for providers with 24 or more workers' compensation bills per month

Beginning November 1, 2019, NJSA 34:15-143, et seq. mandates that any provider with 24 or more workers' compensation bills per calendar month are required to submit them electronically.

When electronically submitting workers' compensation bills directly to QualCare, please use the Jopari Healthcare **payer ID J4059**. Jopari Healthcare is the vendor we have contracted with for the electronic transmission of workers' compensation bills data for payment determination.

Bill submission options for all other providers

Please continue to submit Billson applicable forms electronically through appropriate means.

Important terms and definitions

Term	Definition
Bill	Medical expenses for specific treatment related to a work-related injury or illness that is submitted to payor with appropriate coding and all supporting documentation to request payment for medical services rendered.
Bill Review	State pricing and/or payor edits applied prior to sending to network for pricing against PPO contracted rates.
Compensability or compensable	A determination that an illness or injury has resulted out of, and in the course of, a claimants' employment with a participating entity.
Covered employee	A person who is eligible to receive occupational medical care and other workers' compensation benefits from their employer.
Managed care organization (MCO)	A health care provider, or a group or organization of medical service providers, that offers managed care health plans. Qual-Lynx/QualCare provides managed care services by using case managers to coordinate medical services for claimants, as well as communicate with the bill adjuster and employer.
Maximum medical improvement (MMI)	This occurs when a claimant reaches a state in which their condition cannot be improved further, or a person's healing process reaches a treatment plateau and treatment options have been exhausted.
Network access client	An employer group or insurance carrier (client) that accesses providers in the QualCare workers' compensation network.
Occupational medical care	All medical services and treatments to which a covered employee is entitled under the workers' compensation law for a claim.
Payor	The company responsible for paying medical bills on behalf of the employer group.
Workers' compensation	Workers' compensation is a form of insurance that provides wage replacement and medical benefits to employees injured in the course of employment.
Workers' compensation law	Applicable statutes and regulations (NJSA 34:15) governing workers' compensation benefits for a covered employee making a claim.
Utilization management (UM)	Evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.