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Introduction

The PacifiCare of California Per Diem Hospital Manual is designed to provide important information about PacifiCare and its Hospital operational procedures.

PacifiCare provides coverage for Commercial and Medicare members. PacifiCare’s Commercial benefit packages vary based on the benefits purchased by employer groups.

PacifiCare of California has contracted with the Health Care Financing Administration (HCFA) to offer Secure Horizons, a Medicare + Choice Plan (M+C), to Medicare eligible beneficiaries. The contract authorizes Secure Horizons to arrange for comprehensive health services for beneficiaries who choose to enroll in Secure Horizons. As an approved M+C Plan, Secure Horizons agrees to abide by all laws and regulations applicable to recipients of Federal funds and to ensure our contracted network abides by all such laws and regulations. Secure Horizons covers all services and supplies offered by Medicare in addition to certain services and supplies not covered by Medicare.

The face of the health care industry is constantly changing. All of us are becoming more accountable for the quality of care provided to patients as evidenced through accreditation standards required by the National Committee for Quality Assurance (NCQA), reporting of Health Plan Employer Data and Information Set (HEDIS) indicators, Health Care Financing Administration (HCFA), Joint Commission on Accreditation of Health Care Organizations (JCAHO), and other State and Federal Regulations. Such scrutiny highlights member satisfaction, the quality of health care and financial responsibility, which has created an even more demanding environment in which to practice medicine.

PacifiCare works with its contracted Hospitals to ensure the quality of care rendered to its members, therefore the administration of the PacifiCare plan should be consistent with the guidelines set forth in this manual. PacifiCare and the Hospital work together to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency and ethnic backgrounds and physical or mental disabilities.

PacifiCare and the Hospital ensure that members with disabilities are provided the assistance necessary to effectively communicate with providers and their staff. PacifiCare also ensures that members are not unlawfully discriminated against on the basis of race, color, creed, national origin, ancestry, religion, sex, marital status, age (except as provided by law) or physical or mental handicap.

PacifiCare’s Network Management Associates are available to assist you in learning the policies and procedures outlined in this manual.
Introduction

To the extent that conflicts (as determined by PacifiCare) are identified between the provisions of this Hospital Manual and any contract with PacifiCare, the provisions of the contract shall override the manual.

PacifiCare Background

PacifiCare was fostered by the Lutheran Hospital Society of Southern California, a nationally known hospital management company. PacifiCare was founded in 1975 to provide comprehensive health care to individuals and families residing in the Southern California area and has since grown to encompass nine states.

PacifiCare is not designed to interfere with the private practice of medicine, a concept in which we firmly believe. Rather, it is intended to offer individuals the opportunity to choose an alternative system of payment for the care they receive.

Preventive medicine and cost containment are cornerstones of PacifiCare’s philosophy. Through health education and easy access to routine health care services, PacifiCare members are encouraged to adopt a healthy lifestyle.

PacifiCare’s ultimate success – for its members and its providers alike – lies in quality patient care and consumer satisfaction.
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Eligibility/Benefits/Copayments

Eligibility & Benefit Verification Procedure

A member's eligibility and benefits must be verified each time he/she receives Hospital services.

Eligibility and benefit verification is essential for the following reasons:

- New members may present a copy of the Medicare+Choice individual election form as temporary identification until enrollment is confirmed
- A new Medicare+Choice member’s enrollment may be delayed due to an incomplete election form
- Member may have changed Network
- Member may have been disenrolled from PacifiCare or Secure Horizons
- Employer group may change benefit plans
- Benefits may change for Medicare beneficiaries
- Supplemental benefits may be added
- To determine co-payment based on selected plan
- Fraudulent use of health plan coverage based on selected plan
- The Medicare + Choice plan may exit the service area
- To determine member’s correct Network affiliation for appropriate network specialty referrals

Note: Members are required to present an I.D. card or enrollment form prior to receiving medical services. The I.D. card does not guarantee eligibility; it is for identification purposes only.

Mechanisms for Checking Eligibility & Benefits

PacifiCare provides several ways to verify eligibility and benefits including:

- Voice Response Unit (VRU)
- On-line Eligibility Data
- Member/Customer Service
Eligibility/Benefits/Copayments

Mechanisms for Checking Eligibility & Benefits (cont.)

Voice Response Unit (VRU)  PacifiCare’s Voice Response Unit (VRU) is available 24 hours a day, seven days a week at:

1-800-542-8789

The VRU provides eligibility and minimal benefit information at a member level for past and present dates of service. The following information is available through the VRU:

- Member identification number
- Medical Group/IPA assignment
- Primary care physician assignment
- Eligibility verification number, for your records
- Plan code/coverage
- Hospital and office visit copayment
- Emergency room copayment and waiver information
- Other copayment and benefit information

On-Line Eligibility  The On-Line Eligibility service provides easy access to eligibility and minimal benefit and copayment information. You can place up to 10 eligibility requests at a time and receive a printout of the information. Visit the PacifiCare/Secure Horizons On-Line Eligibility website at:

www.pacificare.com
or
www.mypacificare.phs.com/providers
Mechanisms for Checking Eligibility & Benefits (cont.)

On-Line Eligibility (cont.)

The hospital must use the PacifiCare hospital ID number in order to access the system. A PacifiCare Network Management Operations Associate can provide the hospital contact with the PacifiCare ID number and assist with any questions regarding the website. Upon initial access to the website the hospital contact will register for a password. A temporary password will be sent to the hospital within 5 to 7 working days. Through a subsequent login, the hospital contact will be required to change the temporary password and answer two security questions for future website access. This process is designed to ensure the security of the website. To ensure confidentiality of information, we recommend that the hospital contact does not disclose the password or security question responses.

On-line eligibility provides an eligibility confirmation number and basic member eligibility information including:

- Member identification number
- Member gender
- Provider group/primary care physician name
- Provider group number
- Effective date
- Plan code
- Office visit copayment
- Hospital affiliation
- Hospital copayment
- Emergency room copayment and waiver
- Provider and Group history
### Mechanisms for Checking Eligibility & Benefits (cont.)

#### Member Service
In the event that the VRU or the PacifiCare website is inaccessible or if more detailed benefit information is needed, the PacifiCare Member/Customer Service Department is available to provide member information to providers. Contact the Member/Customer Service Department at the following:

1-800-624-8822

#### Copayments
A copayment is a fee paid by the member at the time of service. Specific copayments are listed on the Schedule of Benefits.

#### Collection of Copayments
The hospital should collect applicable copayments in accordance with the member’s coverage plan.

Member materials instruct the member to pay their copayments at the time of each visit. Emergency room copayments may be collected at the time of the service. If not paid at the time of the service, the members may be billed for copayments. (Check benefits for admissions following emergency room visits.)

#### Confidentiality
PacifiCare and its contracted hospitals and hospital providers are required to safeguard the confidentiality and accuracy of member records that identify a particular enrollee, including both medical documents and enrollment information. Specific enrollee information will not be disclosed outside the organization without specific authorization from the enrollee.

#### Member Rights and Responsibilities
PacifiCare provides to its members information regarding Member Rights and Responsibilities which are designed to educate members about their rights and responsibilities concerning their health care needs and the services they receive. Please contact Network Management Operations Associate for a copy.
Eligibility/Benefits/Copayments

**Medicare Member Communication**

PacifiCare/Secure Horizons is required through the Medicare+Choice contract with Centers for Medicare and Medicaid Services (CMS) to ensure that "any and all communications from any of our contracted entities to a Secure Horizons Member" receive CMS approval prior to their distribution to any Secure Horizons Member.

To clarify, contracted entities include, but are not limited to, Medical Groups/IPAs and Providers (including Hospitals and Hospital Providers). Communications include, but are not limited to, provider termination notices, provider address changes and information about or invitations to "Health Fairs". Communications do not have to refer to Secure Horizons by name to require CMS approval, the determining factor necessitating CMS approval is that they will be distributed to Secure Horizons members.

All member communications must be discussed and approved by Secure Horizons. Contact your Network Management Associate before sending communications out to the member.
Enclosed is your identification (I.D.) card and one for each of your eligible dependents. Please replace any existing cards you have with the new I.D. card, carry the card at all times and use it when receiving services. Please take a moment to verify that the information shown on your I.D. card is accurate, including the spelling of your name and your date of birth.

If you selected a physician affiliated with a Participating Medical Group, the Medical Group name will show on the I.D. card. We encourage you to establish a relationship with the Participating Medical Group or Primary Care Physician you have selected. This will be the focal point of your health care. The Customer Service Department will assist you should you need to change your Primary Care Physician or Participating Medical Group.

If you have any questions or concerns regarding your PacifiCare coverage or need to correct information on your I.D. card, please call our Customer Service Department weekdays from 8:00 a.m. to 8:00 p.m. at 1-800-624-8822.

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**YOUR PACIFICARE I.D. CARD**

<table>
<thead>
<tr>
<th>PacifiCare®</th>
<th>PacifiCare®</th>
</tr>
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<td><strong>Name</strong></td>
<td><strong>Name</strong></td>
</tr>
<tr>
<td>SMITH, TIMOTHY C.</td>
<td><strong>THIS CARD IS VOID</strong></td>
</tr>
<tr>
<td><strong>Member No.</strong></td>
<td><strong>Member No.</strong></td>
</tr>
<tr>
<td>2049506-01</td>
<td>DOB 03-17-64</td>
</tr>
<tr>
<td><strong>DOB</strong></td>
<td><strong>DOB</strong></td>
</tr>
<tr>
<td><strong>Physician or Medical Group Name</strong></td>
<td><strong>Physician or Medical Group Name</strong></td>
</tr>
<tr>
<td>001980 LARAMIE, JOANN H</td>
<td><strong>PCP Effective Date</strong> 08-01-00</td>
</tr>
<tr>
<td><strong>Phone #</strong> (559) 381-6300</td>
<td><strong>Plan</strong> T31</td>
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<tr>
<td><strong>PCP Effective Date</strong></td>
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Eligibility/Benefits/Copayments

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Medical Management Program

Purpose

PacifiCare maintains a comprehensive Medical Management Program to conduct:

- Prospective Review (prior-authorization)
- Concurrent Review (telephonic and onsite review)
- Discharge Planning
- Retrospective Review
- Case Management
- Medical cost management utilizing data and reports
- Monitoring of quality outcomes

The Medical Management Program is designed to assure consistent quality care and cost effective, medically necessary utilization of services for PacifiCare members. Further, this must be done in a manner compliant with all regulatory requirements. The program applies to Covered Services delivered in both inpatient and outpatient settings. The Program replaces the Plan formally referred to as the PacifiCare Utilization Management (UM) Plan.

The Program assures that contracted providers have adequate systems and resources in place for the optimal management and delivery of health services to members. It supports the identification of members with complex and serious conditions to assure that appropriate care and services are rendered.

Compliance

The hospital and hospital providers will participate, cooperate and comply with all operational aspects of PacifiCare’s Medical Management and Utilization Management Programs with respect to health care services provided or arranged for by the hospital and hospital providers.
Medical Management Program

Compliance (cont.)
PacifiCare requires that Covered Services performed on behalf of its members be provided in a culturally sensitive manner, including to those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental impairment. The program is maintained in accordance with the requirements of State and Federal Law and the standards of Accreditation Organizations.

Complying with PacifiCare’s MM Program includes, but is not limited to the following:

- Responding to requests from PacifiCare regarding utilization management activities
- Maintaining accurate, timely and consistently formatted medical records
- Making available Medical Records pertaining to PacifiCare members, as requested
- Assisting PacifiCare’s Medical Management Staff in Case Management and Discharge Planning
- On-site access to PacifiCare members while in the hospital and access to member’s medical records

Structure
The MM Program structure contains the following components:

- Documents the role, accountabilities, and membership of the MM Committee
- Identifies the staff who are responsible for specific MM activities
- Identifies the scope of the program, including MM functions performed and a list of the services covered by each MM function or protocol
- Specifies the criteria used to determine medical necessity including the method by which the criteria is developed or chosen and the method by which criteria is reviewed, updated and modified, as appropriate
Medical Management Program

Structure (cont.)

- Identifies the process by which the medical necessity of inpatient and outpatient services is determined, including those staff members who have the authority to deny coverage
- Specifies the data and information used in making determinations (e.g., patient record, physician request information, conversation with appropriate physicians, etc.)
- Documents the procedures by which a member and provider can appeal a determination
- Documents the role of the MM Program in the Quality Management (QM) Program, including how information is collected and used for QM activities
- Documents the timeliness for determination and correspondence processes
- Provides a clear definition of authority and accountability for all MM activities between PacifiCare and any entities to which PacifiCare delegates MM activities, which are specified in any delegation agreements
- Documents the mechanism for review and update of the MM Program description on at least an annual basis

Notification Requirements

For PacifiCare to have an effective medical management program PacifiCare must receive prior notification of all admissions, changes in patient status and discharge dates daily. Notification allows PacifiCare to verify eligibility, provide the Hospital with a tracking number and notify Medical Management staff for clinical review and authorization as outlined in this manual. Proper notification will facilitate timely and accurate claims payment. Issuance of a tracking number does not constitute authorization for admission; the PacifiCare Authorization Process is outlined below.

Failure to comply with the notification requirements shall result in non-payment to the Hospital and its Hospital Providers for all days and charges until notification is received and services have been authorized.
Medical Management Program

Notification Requirements (cont.)

Admissions

The hospital is required to notify PacifiCare telephonically prior to all acute and elective admissions by calling 800-872-5570. This notification line is open 24 hours a day, 7 days a week, 365 days a year. For Emergency admissions, notification should occur once the patient is stabilized in the Emergency Department.

Census Reports

The following reports are required to be faxed daily to PacifiCare’s Clinical Information Department at 800-978-7457:

- Census report for all PacifiCare/Secure Horizons Members
- Discharge Report
- Face Sheets to report OP Surgeries or SNF admissions
- Inpatient Admission Fax Sheet to report “no PacifiCare/Secure Horizons admissions” for that day

The census report or face sheets should contain the following information:

- Primary Medical Group Name
- Admit date
- Member name (first and last)
- Date of birth
- Bed type/accommodation status/level of care (LOC)
- Length of Stay (LOS)
- Admitting physician
- Admitting diagnosis (ICD9)
- Procedure/surgery (CPT Code) or reason for admission
- Attending Physician
- Hospital (facility)
- City/State
- Policy Number
- Other Insurance
- Authorization number (if available).
Notification Requirements (cont.)

Census Reports (cont.)

The Discharge Report should include Member demographic information plus the:

- Discharge Date
- Disposition

With hospital’s I.S. support, PacifiCare can also support various electronic data interface (EDI) solutions to facilitate more timely transmission of census information.

Prior Authorization Process

Pre-Certification/Prior Authorization/Prospective Review is defined as Prior assessment that proposed services, such as hospitalization, diagnostic testing, specialty referral, Physical Therapy, Occupational Therapy, Speech, Home Health, etc., are appropriate for a particular member and will be covered by the Plan. Payment for services depends on whether the member and category of service are covered by the member’s benefit plan.

All non-emergent and direct acute care hospitalizations and skilled nursing admissions require prior authorization and all emergent admissions require immediate notification. Prior Authorization provides the requesting provider and/or hospital an opportunity to prospectively (before services are rendered and costs incurred) assure that:

- The patient is an eligible PacifiCare Health Plan Member

- The benefit(s) is a covered service available under the Member’s health plan Evidence of Coverage. If a service is considered to be experimental or investigational, the service may NOT be covered under the Member’s Health Plan. For further clarification regarding Experimental or Investigational Services, please contact PacifiCare’s Prior Authorization Department at 800-762-8456.
Prior Authorization Process (cont.)

- All Covered Services (e.g., tests, procedures) within the physician’s scope of practice have been provided and evaluated thoroughly prior to specialist or hospital involvement in order to:

  1. Avoid unnecessary consultations or admissions and delays in services where the requesting physician can provide the service and
  2. To provide the respective specialists and hospital with sufficient medical information to evaluate a Member’s condition.

- Consultation requests are directed to a physician and/or facility that has been contracted, credentialed, and/or approved by PacifiCare.

- The Covered Service requested is directed to the most appropriate contracted specialist, facility, or vendor (i.e., formal Provider/Hospital Professional Affiliations take priority over non-affiliated hospitals, contracted hospital providers take priority over non-contracted hospital providers, and in-network hospital contracts take priority over out-of-network hospital contracts).

- The service is provided at the appropriate level of care (i.e., outpatient vs. inpatient or at appropriate level of inpatient care).

- The service meets criteria for Medical Necessity (according to accepted nationally recognized resources such as Milliman & Robertson, InterQual, etc.).

- Continuity of care is preserved (i.e., the Primary Care Physician is kept apprised of service requests made on behalf of the Member and services provided to Members by other providers; the Member is directed to the same specialist or vendor, where possible, for continued health care services).
The Prior Authorization process allows for the early identification and reporting of the following:

- Third Party Liability Cases
- Institutionalized Members
- Members with End Stage Renal Disease
- Members receiving Hospice Care
- Quality Care Issues
- Primary and Secondary Insurance Information (Coordination of Benefits)
- Anticipation of Future Care Requirements and Associated Costs
- High occurrence conditions that may benefit from intensified and coordinated ambulatory care
- Members who may benefit from Case Management

Failure to comply with prior authorization and notification requirements shall result in non-payment to the Hospital and its Hospital Providers for all days and charges until notification is received and services have been authorized. In no event shall PacifiCare or the Member be held responsible to reimburse Hospital and its Hospital Providers for admission, or inappropriate hospital days and/or such medically unnecessary services if prior authorization was not obtained.

Emergency Services are Covered Services required by a member as the result of a medical condition manifesting itself by the sudden onset of symptoms of sufficient severity, which may include severe pain, such that a reasonable person would expect the absence of immediate medical attention to result in:

1. Placing the health of the Member in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily part.

The final determination of whether Emergency Services were required shall be made by the PacifiCare medical director or designee, subject to appeal under the applicable Member appeals procedure.
### Medical Management Program

#### Emergency Services/Urgently Needed Services (cont.)

Urgently Needed Services are Covered Services under a Managed Care Plan which are required without delay in order to prevent the serious deterioration of a Member’s health as a result of an unforeseen illness or injury and it was not reasonable, given the circumstances, to obtain the services in accordance with the terms of the applicable Managed Care Plan.

The Hospital Emergency Room Department is required to contact the Member’s Primary Care Physician or hospitalist upon the Member’s arrival for services. After stabilization of the Member, no PacifiCare Member may be admitted from the Emergency Room without receiving prior authorization from PacifiCare or its designee, except as outlined below under Emergency and/or Direct Urgent Hospital Admissions.

#### Post Stabilization Care

If a Member requires Medically Necessary, non-emergency services, PacifiCare arranges for, or provides coverage to a Member from the time a medical provider or facility requests authorization from PacifiCare or its designee, or the medical Group/IPA until:

- The Member is discharged
- PacifiCare or its designee arrives and assumes responsibility for the Member’s care
- The non-contracted medical provider and PacifiCare or its designee agrees to other arrangements

#### Emergency and/or Direct Urgent Admissions

If the Hospital does not receive authorization from PacifiCare or the Member’s contracted medical Group within one hour of the initial call requesting authorization for Secure Horizons Members, or within one half-hour of the initial call for PacifiCare commercial members, the emergent and/or urgent services are assumed to be authorized and should be documented as such to the at-risk (responsible) entity until such time that the at-risk entity directs or arranges care for the member. Once PacifiCare or the Member’s contracted Medical Group become involved with managing or directing the Member’s care, all services provided must be authorized by them.
Medical Management Program

Types and Scope of PacifiCare’s Medical Management Process

Concurrent Review

PacifiCare defines Concurrent review as an assessment that determines Medical Necessity or appropriateness of services as they are being rendered, such as an assessment of the need for continued inpatient care for hospitalized patients. Criteria used to evaluate length of stay (LOS) and level of care (LOC) include:

- InterQual
- Milliman & Robertson (M&R), other industry sources
- HCIA Length of Stay designations.

The hospital is required to actively participate and cooperate in the Concurrent review process.

This process includes the following:

Administrative Guidelines for All Admissions

Concurrent review will be performed on all admissions from the day of admission through discharge.

The Program will assure that each day is Medically Necessary, at the appropriate level of care, and that all discharge arrangements have been made. If Concurrent Review suggests that the Member may be treated at a lower level of care or in an alternative treatment setting, the case will be discussed with the treating physician. If a discrepancy occurs PacifiCare’s Medical Director or designee will discuss the Member’s clinical status and treatment plan with the treating physician.
Types and Scope of PacifiCare’s Medical Management Process (cont.)

Concurrent Review (cont.)

PacifiCare will attempt to contact the treating provider two times in a 24-hour period to discuss the discharge. In the event that the treating provider does not cooperate by responding to PacifiCare’s request for information regarding patient disposition within this time period, a facility denial will be issued to the hospital.

Any delays in discharge or variant days attributed to lack of, or delay in providing Covered Hospital Services shall result in non-payment to the hospital for all variant days and charges related to those days. The hospital agrees to be financially responsible for the Covered Hospital Services including variant days and will not bill the Member for any such services. The hospital will receive a denial letter as notification for any such variant days or charges related to those days.

The hospital will cooperate with PacifiCare by:

- Providing telephonic Concurrent review
- Allowing PacifiCare onsite Concurrent review staff to participate in the Concurrent review/discharge planning process
- Allowing PacifiCare staff access to all elements of medical records, including electronic elements
- Providing admission, LOC and discharge notification as required in notification status
- Allowing onsite access to all units in the hospital, including ED
- Permitting bedside access to speak to members and family
- Allowing PacifiCare staff to participate in individual case conferences
Medical Management Program

Types and Scope of PacifiCare’s Medical Management Process (cont.)

Concurrent Review (cont.)

- Facilitating the availability and accessibility of Hospital UM Medical Director for case reviews and medical management discussions with PacifiCare Medical Director as requested
- Supplying PacifiCare, hospitalist, concurrent review nurse, PacifiCare Medical Director and/or delegated PMG/IPA Onsite Nurse with an accurate daily hospital census
- Issuing NODMAR letters to Secure Horizons members
- Providing appropriate services in a timely manner
- Participating in Joint Operations Meetings with PacifiCare on a regular basis

PacifiCare or its agents are responsible for the authorization for medical services provided to a Member. If Hospital has obtained concurrent or prior authorization for a Covered Service provided to a Member, PacifiCare or its agents will not retrospectively deny payment for such prior authorized Covered Service, unless Hospital’s claim and/or medical record for such services do not support the specific services and/or level of care authorized by PacifiCare or its agents. PacifiCare or its agents shall conduct medical management throughout a Member’s course of treatment and multiple authorizations may be required throughout such course of treatment. Hospital acknowledges that initial and subsequent authorizations may be limited to specific services or time periods requiring the Hospital to assure that subsequent authorizations are obtained.
Section B  Types and Scope of PacifiCare’s Medical Management Process (cont.)

Medical Management Program

Types and Scope of PacifiCare’s Medical Management Process (cont.)

Retrospective Review

Failure to comply with PacifiCare’s Concurrent review process – may result in a retrospective review and/or non-payment of hospital and provider services to the hospital and Hospital provider for appropriate days and charges. Retrospective review involves examination of the medical documentation and billing after service has been provided (P&P UM 8070 UM Bill Review). PacifiCare or its designee will issue an initial determination and assign an approved level of care and estimated length of stay – based on criteria upon review against medical necessity criteria.

Elective Admissions

All prior authorized elective admissions will be reviewed from the day of admission through discharge. Subsequent reviews will be performed as the Member’s condition indicates or as requested by PacifiCare or its designee until the Member is transferred to an appropriate level of care, alternative treatment setting or is discharged.

Emergency Admissions

All reviews of emergency admissions will be performed as the Member’s condition indicates, or as requested by PacifiCare or its designee until the Member is transferred to an appropriate level of care, alternative treatment setting or is discharged.

Skilled Nursing Facilities (SNF)

A Skilled Nursing Facility is one that provides inpatient Skilled Nursing care, rehabilitation services or other health related services and is State licensed and/or certified by Medicare. The term “Skilled Nursing Facility” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care.
Types and Scope of PacifiCare’s Medical Management Process (cont.)

Skilled Nursing Facilities (SNF) (cont.)

Prior to transfer/admit to a SNF, PacifiCare’s Concurrent review nurse must approve the Member’s treatment plan. The Participating Physician must perform the initial physical exam and written report within 48 hours of a Member’s admission to the Skilled Nursing Facility.

State and Federal regulations require that skilled level Members continue to be seen by a physician at least once every 30 days. PacifiCare will perform an initial review and subsequent reviews as deemed necessary.

Medical Observation

PacifiCare or its designee will authorize Hospital observation status only when medically indicated by InterQual criteria. Hospital observation status is generally designed to evaluate a Member’s medical condition to determine the need for actual admission, or to stabilize a Member’s condition (less than 24 hours). Typically, observation status is used to rule out a diagnosis or in medical conditions that respond quickly to care. Members admitted under observation status may later be converted to an inpatient admission if Medically Necessary and if appropriate criteria have been met.

Discharge Planning

Discharge planning is the coordination of a patient’s anticipated continuing care needs following discharge. The initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes, but is not limited to, the following:

- Assessment of needs
- Plan Development
- Plan implementation
- Evaluation of effectiveness
Types and Scope of PacifiCare’s Medical Management Process (cont.)

Discharge Planning (cont.)

Discharge planning includes:

- Assessing the patient’s potential discharge requirements beginning day of or day following admission
- Evaluating available support and assistance, financial needs, skilled services and/or DME requirements
- Arranging multi-disciplinary meetings as appropriate to include patient and family if necessary
- Involving social service in discharge plan, as appropriate
- Coordinating discharge needs to include DME, HH, SNF, transportation, medications seven days a week
- Obtaining authorizations for necessary post-discharge plan
- Documenting and communicating the discharge plan
- Ensuring patient understanding of discharge orders, follow-up care required
- Making referrals to Case Management, Population-based and Disease Management programs
- Delivering the NODMAR

The attending physician is required to facilitate discharge planning by documenting the anticipated discharge disposition (home, SNF, other) and any services the Member may require. PacifiCare’s Concurrent review nurse will work with the hospital case managers and discharge planning resources throughout the Member’s hospital stay to arrange for any needed services following discharge.

- PacifiCare’s Concurrent review nurse and the hospital case manager will collaborate on daily assessments to determine any changes in the Member’s condition, needs, support system or resource requirements, etc., which might require alterations in the discharge plan.
Medical Management Program

Types and Scope of PacifiCare’s Medical Management Process (cont.)

Discharge Planning (cont.)

- Early identification of any social, financial or other issues that may delay or complicate discharge will be identified and incorporated into the discharge plan and be resolved early in the hospital stay.
- PacifiCare and the hospital case managers will collaborate on final discharge planning which will include an assessment of the Member’s knowledge and/or understanding of the post-hospital care.
- All discharges may be made only to PacifiCare-approved facilities and utilize PacifiCare-approved transportation providers.
- All equipment and services provided or ordered at discharge must be approved and referred to PacifiCare contracted vendors.
- A current list of PacifiCare contracted vendors will be supplied to the hospital case management department and updated on a periodic basis.
Case Management
Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes (CM P&P definition). Case management targets those Members utilizing, or likely to utilize, excessive medical resources and manage care through interventions. The interventions are focused on proactively managing the care of these Members by controlling resource utilization, preventing inappropriate use of resources such as re-admissions or excessive hospitalizations, and managing optimal outcomes based on the underlying illness or diagnosis.

The PacifiCare Case Manager or designee should facilitate communication and coordination between all Members of the health care team involving the Member and family in the decision-making process in order to minimize fragmentation of the health care delivery system.

The Case Manager is responsible for assessing the needs of the Member, educating the Member and their family (if appropriate) and all Members of the health care delivery team about case management, community resources, insurance benefits, cost factors and issues in all related topics so that informed decisions may be made. The PacifiCare Case Manager or designee is the link between the Member, the providers, the payor and the community.

Population Management Programs
Population Management Programs are available through the case management department. The purpose of these programs is to assist in managing patient populations to produce quality, cost-effective outcomes.

The following are descriptions of various programs:
## Medical Management Program

### Case Management (cont.)

#### End of Life Care Management

*End of Life (EOL) Care Management*

The End of Life Care Management program, implemented by PacifiCare’s Case Management Department in conjunction with physicians, improves the quality of life of patients in areas such as pain management, advanced directives, dying with dignity, psychosocial issues and family issues. Case managers and other clinicians provide compassionate care and effectively manage health care services for patients with incurable diseases, while optimizing clinical and social outcomes.

*Enrollment criteria: any terminal disease process (12 months or less life expectancy)*

### Frail Member at Home

*Frail Member at Home:*

The Frail Member at home program is a case management-focused program designed to maintain the patient’s functional independence at home and prevent unnecessary emergency room and inpatient utilization. In coordination with the physician(s), case managers provide comprehensive care management, which may include coordination of health care services, community resources and social work referrals.

*Enrollment criteria: utilization of hospital two or more times or access of ER two or more times during the past 12 months and use of four or more multiple medications*

### Emergency Room Frequent Utilizers

*Emergency Room (ER) Frequent Utilizers:*

The ER Frequent Utilizer program is a case management-driven program providing interventions for Members who may be accessing the emergency room inappropriately. The case manager gathers information from the patient, the family or caregiver, and the physician(s) to determine the nature of frequent ER visits. A case management care plan is developed in conjunction with the physician to facilitate the coordination of health care services, community resources and social work referrals as needed.
Medical Management Program

Case Management (cont.)

Emergency Room Frequent Utilizers (cont.)

Enrollment criteria: utilization of the ER two or more times within a six-month period.

Catastrophic Case Management

A catastrophic condition is defined as an illness or injury characterized by a high intensity of service integration and is associated with high resource utilization. The Hospital and its Participating Physicians and Providers must notify PacifiCare or its designee promptly when it identifies any suspected catastrophic cases.

If the catastrophic case is an emergency, the Hospital and it’s Participating Physicians and Providers must notify PacifiCare or its designee of the admission PRIOR TO ADMISSION.

The case will be followed in PacifiCare’s Utilization Management department and will be referred to Case Management if the diagnosis or length of stay meets the criteria for Case Management. Cases may be referred to case management either by internal or external referral sources.

Based on the Member’s need for Medically Necessary services, PacifiCare or its designee can assist in facilitating the transfer of catastrophic cases to skilled nursing facilities or arrange care through other providers if necessary.

PacifiCare or its designee may coordinate with the attending physician to transfer a Member currently receiving care in a hospital or skilled nursing facility to an alternate appropriate level of care.
Case Management (cont.)

Social Services Case Management

PacifiCare has designated a Licensed Social Worker who acts as a consultant to its internal case management staff and provides case management interventions specific to those members who are high utilizers of health care services due to mental health issues, psychosocial issues, frailty, non-compliance or end of life care issues.

Social Services Case Management interventions include:

- Hospice education/referral
- Community services referrals
- Consultant to internal case management
- Coordination of mental health interventions
- Conflict resolution
- Assistance with long term care placement
- Facilitating discharge planning
- Educating members on alternative options for care available through local and state funded agencies

Summary of Case Management Programs

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<td>Catastrophic-high dollar case with claims cost of $50,000 (in last 12 calendar months) or greater, member has complex needs and requires coordination of multiple services; condition is not terminal. Example: shift nursing care, ventilator dependent patient.</td>
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## Medical Management Program

### Summary of Case Management Programs (cont.)

| **End of Life** | End of Life-member has a 12-month or less life expectancy. This includes any diagnosis and is not limited to oncology diagnosis. In addition, this would include diagnosis that are life limiting in which the life expectancy may exceed 12 months and it is anticipated that the clinical course is progressively deteriorating and life care planning is required; i.e. ALS patient who is on a ventilator and is progressively worsening. Category includes any referral type where the member has a life expectancy of less than 12 month; i.e. Senior HRA or ER Utilizer. |
| **Frail Member** | Frail Member-member has accessed 2 or more ER visits, and 2 or more hospitalization in the past 12 months and uses multiple medications of 4 (four) or more. Member does not meet criteria for End of Life. Category includes referrals from Senior HRA's. |
| **ER Utilizer** | ER Utilizer-member has accessed the ER 2 or more times in a 6-month period of time and does not meet criteria for End of Life. |
| **Cardiovascular Conditions** | Aneurysm  
Cardiac bypass with complications  
Cardiomyopathy  
CVA (stroke) with significant neurological deficit  
Myocardial Infarction with complicating factors  
CHF |
| **Malignancy Conditions** | Brain Tumors  
Recurrent malignancies |
| **Neurologic Disorders** | Amyotrophic Lateral Sclerosis (ALS)  
Anoxic brain damage  
Encephalopathy  
Guillian Barre  
Head Injuries  
Meningitis (complicated)  
Multiple Sclerosis  
Muscular Dystrophy  
Myasthenia Gravis  
Prolonged coma  
Spinal Cord Injuries |
| **Obstetric Conditions** | High Risk pregnancy  
**Previous history of ICU-confined neonate** |
| **Pediatric Conditions** | Chemically dependent infant  
Complex neonates / pediatric cases  
Severe congenital anomalies  
Premature neonates |
| **Renal Conditions** | ESRD / Renal failure (with possible transplant) |
Summary of Case Management Programs (cont.)

| Metabolic Disorders          | Diabetes Mellitus Admit  
|                             | Myxedema Coma           
|                             | Thyroid Storm           
| Transplant Considerations   | Bone Marrow/Stem Cell Transplant  
|                             | Heart Transplant        
|                             | Heart/Lung Transplant   
|                             | Kidney Transplant       
|                             | Kidney/Pancreas Transplant 
|                             | Liver Transplant        
|                             | Lung Transplant         
|                             | Organ Rejection         
|                             | Post Transplant Complications  
| Traumatic Conditions        | Burns with grafting and/or hospitalizations  
|                             | Multiple trauma         
|                             | Spinal cord injury      
|                             | Traumatic amputations   
|                             | Traumatic brain injury  

Continuity and Coordination of Care

It is the responsibility of the Hospital to assist in maintaining the continuity and coordination of a Member’s care by working with the Member’s Primary Care Physician and by advising the Primary Care Physician of any admissions and providing discharge summaries.

It is the responsibility of the Hospital to continue to provide Covered Hospital Services to Members in the event of the termination of its agreement with PacifiCare. Coverage includes service to Members who become eligible during the termination period. PacifiCare or its designee retains the right to transfer Members to other facilities with prior written notice to the Hospital.

The Hospital will continue to provide care to any Members who cannot be transferred within the time frame specified in the written notice to assure continuity of care for PacifiCare’s Members.

The Hospital is prohibited from billing a Member for any authorized Covered Service provided during the termination notice – period (referenced in contract) except for Member co-payments or co-insurances. The Hospital must maintain all appropriate books and records as required by federal, state and local laws, regulations, and policies and must allow PacifiCare, the California Department of Managed Health Care, the federal Center for Medicare and Medicaid Services (formerly known as the Health Care Finance Administration), accreditation organizations, or their designees, access to all PacifiCare/Secure Horizons membership related books and records for a period of seven years from the date of the termination - notice period.
Emergent/Urgent Services Procedures

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### Emergency Services

Emergency services are covered while the member is in-area or out-of-area. Emergency services are:

- Furnished by a provider qualified to render emergency services, and
- Needed to evaluate or stabilize an emergency medical condition

### Medicare Emergency Medical Condition Definition

Medicare defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

### Commercial Emergency Medical Condition Definition

PacifiCare defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

### 911 Emergencies

In an emergency, the member should dial 911 or its local equivalent for ambulance and/or paramedic services.
Emergent/Urgent Services Procedures

Urgent Care Services

Medicare Urgent Care Services Definition
Urgent care services are covered services provided when a member is temporarily absent from the area served by the member’s Primary Care Physician or under unusual and extraordinary circumstances, provided when the member is in area but the member’s Physician is temporarily unavailable or inaccessible and services are medically necessary and immediately required:

- As a result of an unforeseen illness, injury, or condition; and
- It is not reasonable, given the circumstances to obtain the services through the member’s Medical Group/IPA

Note: A temporary absence for a Secure Horizons member is an absence from the Service Area lasting not more than 6 months.

Commercial Urgent Care Services Definition
Urgently Needed Services are provided for less serious medical conditions that result from an unforeseen illness or injury. In these circumstances, the condition is accompanied by symptoms severe enough, a prudent lay person could reasonably expect that a delay in treatment will cause a serious deterioration in his or her health.

Directing Urgent Care Services
Members may have urgent, but not necessarily life-threatening emergencies. In these cases, the member should be directed to the Primary Care Physician’s office (if during office hours) or an Urgent Care Facility whenever appropriate.

Emergency Room In-Area Authorization
When a member accesses care through the Emergency Room, the member must be provided with a medical evaluation to determine whether an emergency medical condition exists and the member’s condition is stabilized. For all emergency room services that result in an admission, the hospital and hospital providers will notify PacifiCare or its delegated entity or designee at the time of service.
### Emergent/Urgent Services Procedures

#### Post-Stabilization Care

PacifiCare provides coverage if a member requires medically necessary, non-emergency services to ensure that the member’s condition remains stabilized.

#### Medicare Post-Stabilization Requirements

For Medicare members, PacifiCare provides post-stabilization coverage from the time a non-contracting medical provider or facility requests authorization from PacifiCare or the contracted Medical Group/IPA until:

- The member is discharged
- PacifiCare or its designee arrives and assumes responsibility for the member’s care
- The non-contracting medical provider and Secure Horizons agree to other arrangements

If the medical provider or the facility does not receive authorization from PacifiCare or the designee within one (1) hour of the initial call requesting authorization, the services are assumed to be authorized and should be processed as such through the claims system of the at-risk entity.

If a PacifiCare representative and/or medical provider representative, and the treating physician cannot reach an agreement concerning the member’s care and a PacifiCare contracted physician is not available for consultation, then the treating physician may continue with care of the member until the PacifiCare contracted physician can be reached.
### Post-Stabilization Care (cont.)

#### Commercial Post-Stabilization Requirements

Post Stabilization Care is the Medical Care necessary to maintain the member’s health after receiving Emergency or Urgently Needed Services. The member’s Participating Medical Group must provide 24-hour access to obtain timely authorization for Medically Necessary Post Stabilization Care.

The member’s medical condition is considered stabilized when, in the opinion of the treating provider and within reasonable medical probability, no material deterioration of his/her condition is likely to result from -- or occur during -- a transfer to a hospital contracted with PacifiCare. Post Stabilization Care ends when the member is transferred to a hospital contracted with PacifiCare. It also ends when he/she is discharged from the hospital or if health care providers authorized through PacifiCare assume treatment.

#### Retrospective Review

PacifiCare or the delegated Network will perform retrospective review of unauthorized services. The review will include a review of all appropriate medical records that would determine medical necessity.

PacifiCare has the final decision-making authority between parties for payment of claims for covered services rendered to members, determination of medical necessity, level of care, length of stay, covered services, determination of eligibility and member benefits.

#### Reciprocity

The hospital and hospital providers will assure reciprocity of health care services for members who are enrolled in Managed Care Plans and health benefit plans of PacifiCare’s affiliates. For example:

- A member needs to receive urgent or non-urgent care from their in-network hospital. However, due to the nature of the illness and the distance to the hospital it may be appropriate to authorize treatment at another PacifiCare affiliated entity.

- The hospital will deliver medical services to members who are not in-network with the hospital, including members enrolled in the managed care and health benefit plans of PacifiCare affiliates.
Reciprocity

- The hospital will accept reimbursement rates as outlined in their PacifiCare agreement, less any applicable copayment as “payment in full”.

Emergent/Urgent Services Procedures
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Quality Management

Quality Improvement and Management Program

The PacifiCare Quality Improvement Program ("QI Program") is designed to be used by hospitals and hospital providers to assess and improve the quality of clinical care and service provided to our members input. It is a program that actively involves the provider with the emphasis on change through education. PacifiCare’s QI Program is maintained in accordance with the requirements of state and federal law and the standards for accrediting organizations. The QI Program is developed with participating provider, purchaser, and member input to address the specific needs and demographics of the enrolled population.

Participating hospitals and hospital providers will participate, cooperate and comply with PacifiCare in the operations of the QI Program to ensure that members receive covered services consistent with professionally recognized standards of medical and hospital practice.

Active involvement includes, but is not limited to:

- Conducting peer review
- Collecting data and providing access to medical records
- Identifying barriers when opportunities for improvement are identified
- Implementing targeted interventions

Member Rights and Responsibilities/ Roles

PacifiCare has established a policy and member-specific information regarding members' rights and responsibilities/roles that are consistent with PacifiCare’s policies and that meet state and federal regulatory requirements as well as external accreditation standards. This information is shared with members and providers so that they may be aware of their accountabilities as well as PacifiCare’s commitment. Hospitals and hospital providers will adhere to PacifiCare’s Member Rights and Responsibility/Roles statement. PacifiCare distributes the statement to both new and existing providers as well as members. The statement is available by calling your Network Management Associate.
Quality Management

Confidentiality of Member Information

Members have a right to be protected against unauthorized disclosure and use of information pertaining to them. This right shall be protected by a presumption against disclosure and applies to all settings. The procedure for the handling and flow of medical records, reports, and other written materials throughout the facility shall ensure that these records, reports, and materials are at no time accessible to unauthorized persons or entities. Member's explicitly or implicitly identifiable health and enrollment information shall not be released unless:

- Written consent, either routine or special, from the member has been obtained; or

- Release of information is authorized by law; or

- When there is a valid insurance-related, plan-related, or health-related need to know by a person whose job description or position in PacifiCare has the authority to request and evaluate any member-specific issues.

Routine Consent

Upon enrollment, each member, or their legal representative, will sign a routine consent statement. Routine consents permit PacifiCare, or its contracted associates, to obtain and use the member’s protected confidential member health information for the purposes related to treatment, payment, or PacifiCare operations. Routine consent does not include permission to obtain or use protected health information that is protected by law, such as a member’s psychotherapy notes.

Authorization/Special Consent

To the extent that member information is to be used outside the scope of a routine consent, the member, or their legal representative, prior to the use and/or disclosure of that information must sign an authorizations/special consent form. The form must document:
Quality Management

Confidentiality of Member Information (cont.)

Authorization/Special Consent (cont.)

• The protected class of confidential member health information to be obtained

• The purpose for which the information will be used

• The duration the authorization/special consent is in effect

A copy of consent form must be kept in the member’s medical record or case file for a minimum of six years.

Note: Psychotherapy notes always require an authorization/special consent for use and release. Other categories of records that may require an authorization/special consent for use and release include but are not limited to medical records related to the treatment of a mental illness, results of genetic testing and blood tests for HIV.

Members Unable to Give Consent

For members unable to give consent, the hospital or hospital provider must state how it determines the individual who may authorize the release of information, authorize the member’s care and treatment, and have access to information about the member.

Providing Access to Confidential Member Health Information

Members may access their confidential member health information (including medical records) at any time by contacting the hospital or hospital provider directly. Members must be given the opportunity to review their medical records in a timely fashion. The provider has a right under certain circumstances to deny access to medical records if the provider believes release of the records will cause substantial harm to the member or another person.
Confidentiality of Member Information (cont.)

Providing Access to Confidential Member Health Information (cont.)

Confidential member health information is not to be sent or received by fax equipment that is shared by parties not authorized to have access to the information or is not dedicated for use by authorized parties, unless arrangements have been made to verify that the intended party receives the information and removes it from the fax equipment immediately.

Use of Measurement Data

PacifiCare will inform participants in PacifiCare’s peer review and/or quality improvement activities:

- Of the immunities available to them under the Federal Health Care Quality Improvement Act and related state laws and

- That such immunities may be compromised, thereby exposing participants to liability, if participants improperly disclose confidential peer review and/or quality improvement information outside of the professional review proceeds

The release of quality improvement information containing specific enrollee information will not be circulated outside the organization without the specific authorization from the enrollee. Release of information will be in accordance with state and federal laws.

Employer Groups and Purchasers

Individual member data will not be shared with employers, even self-insured employers, unless required by law or pursuant to and authorized by special member consent.
Access and Availability Standards

Hospital and hospital providers are required to provide hospital services to members twenty-four (24) hours a day, seven (7) days a week. The hospital is required to maintain sufficient staffing in order to provide hospital services to meet the needs of PacifiCare and its members in accordance with PacifiCare’s QI Program and state and federal law.

Continuity and Coordination of Care

PacifiCare members are assigned a primary care physician at the time of enrollment. The primary care physician is designated as having primary responsibility for coordinating the member’s overall health care, including behavioral health care, the appropriate use of pharmaceutical medications, and continuity across different sites of care (such as between the physician and hospital, home health or skilled nursing facility). To assist in this effort, a discharge summary should be sent to the member’s Primary Care Physician by the hospital upon discharge or transfer from the hospital.

In the event of termination of the Agreement between the hospital and PacifiCare, at PacifiCare’s request, the hospital and its hospital providers will copy all requested member medical records in their possession and forward such files to another provider of covered services designated by PacifiCare, unless such copying and forwarding is not otherwise objected to by such members. The copies of the medical records may be in summary form.

Medical Record Documentation

Medical records are the data source that documents the services provided to our members and verify the quality of the healthcare provided by participating practitioners. PacifiCare and regulatory review entities frequently use this documentation to assess quality of care. Medical record documentation is used in the resolution of member grievances and appeals related to their healthcare. The medical record is a legal document subject to discovery during litigation. The hospital and hospital providers may be requested to certify the accuracy, completeness, and truthfulness of medical records by legal and regulatory agencies. The medical record must be retained for six years.
Medical Record Documentation (cont.)

PacifiCare recognizes that the information contained in medical records is highly confidential. All Providers should have policies and procedures to ensure the confidentiality of member information. Employees with access to medical record information should have confidentiality statements on file. Medical records are to be stored in a location secure from public access. Any request to release medical records, for purposes other than those covered under routine consent, requires patient consent before release to any source.

On at least an annual basis, PacifiCare will require access to medical records for HEDIS® reporting. HEDIS reporting is required by selected purchasers, state and federal regulatory and accrediting agencies.

Advance Directives

Federal and state laws require members to be informed of their right to make health care decisions and execute Advance Directives. An Advance Directive is a formal document written by the member in advance of an incapacitating illness or injury. There may be several types of Advance Directives that the member can choose, depending on state laws. Most states recognize:

- Durable Power of Attorney of Health Care (DPAHC).
- Living Wills
- Natural Death Act Declarations

PacifiCare requires that all hospitals and hospital providers are in compliance with key requirements in the Patient Self-Determination Act (PSDA). The hospital and hospital provider must maintain written policies and procedures that contain:

- Provide written information to each adult patient concerning their right to make decisions regarding health care;
- Document, in the individual’s medical record, whether or not the individual has executed an Advance Directive;
Advance Directives (cont.)

• Document, in the individual’s medical record, whether or not the individual has designated an adult as a surrogate to make all health care decisions effective only during the course of treatment when the designation is made;

• If a member has executed an Advance Directive, a copy of the document must be prominently displayed in the member’s medical record; and

• Provide for education of hospital staff concerning Advance Directives.

PacifiCare members are not required to initiate an Advance Directive and can not be denied care if they do not have one. A sample copy of an Advance Directive Form is available by calling the PacifiCare Member Service Department at 1-800-624-8822 or by calling the Secure Horizons Member Service Department at 1-800-228-2144.

Quality Improvement and Health Management Programs

PacifiCare’s Quality Initiatives address the health care needs of our entire member population, from newborns to the elderly, and target common medical conditions that occur frequently among our membership. Many of them also involve collaboration with academic and professional experts in quality of care and improvement. The main goal of these initiatives is to demonstrate improvement in the quality of care that our members receive. Additionally, these initiatives are designed to promote self-care. PacifiCare believes that, given appropriate information and support for using it, health plan members can be full partners in managing their health. A collaborative work effort with our Providers, throughout all phases of our Quality Improvement Program, is required to accomplish this goal. For a listing of Quality Improvement and Health Management Programs contact your Network Management Associate.
Member Appeals

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Member Appeals

**Introduction**

The procedures described in the sections that follow are used if the member has an appeal or grievance to submit to PacifiCare for review and resolution. These procedures include:

- PacifiCare Organization Determination and Appeals Process
- PacifiCare Expedited/72-Hour Determinations and Appeals Procedure
- Peer Review Organization (PRO) Immediate Review of Hospital Discharges
- PacifiCare Grievance Procedure
- Arbitration is available for disputes except those claims and services subject to the Medicare reconsideration and appeals process.

In support of their health plan regulatory effort, the Department of Managed Health Care (DMHC) has established a toll-free phone number for members who would like help with a complaint: (800) 400-0815.

**Member Appeals Process**

In compliance with federal law, PacifiCare provides a standard determination and appeals procedure for its members. The Appeals Procedure pertains to disputes involving an initial determination decision with which the member (or an authorized representative of a member) is dissatisfied.

**Types of Services that may be Appealed**

Members have the right to appeal any decision about PacifiCare payment for covered services or failure to arrange or continue to arrange for covered services. Examples of appeals include:

- Payment for emergency services, post-stabilization care, or urgently needed services, out-of-area and routine travel renal dialysis.

- Payment for any other health services furnished by a Non-Contracting Medical Provider or Facility that the member believes should have been furnished, arranged for, or reimbursed by PacifiCare.
Member Appeals

Types of Services that may be Appealed (cont.)

- Discontinuation of a service, if the member disagrees with the determination that the service is no longer medically necessary.

Members use the PacifiCare Grievance Procedure for complaints that are not denied claims or denied services.

Expedited/72-Hour Determination of Appeals Procedures

Medicare+Choice (M+C) members have the right to request and receive expedited decisions affecting their medical treatment in “time-sensitive” situations. A time-sensitive situation, as defined by CMS, is a situation where waiting for a decision to be made within the time frame of the standard decision-making process could seriously jeopardize the life or health of the member, or their ability to regain maximum function. If PacifiCare decides, based on medical criteria, that the member’s situation is time-sensitive or if any physician calls or writes in support of the member’s request for expedited review, PacifiCare will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request.

Peer Review Organization (PRO) Immediate Review of Hospital Discharges

M+C members being discharged from the hospital must receive a written notice of explanation, which advises them of their rights to appeal the discharge decision. The hospital must cooperate in assisting PacifiCare or its designated Medical Group/IPA in ensuring that the “Important Message about Medicare Rights: Admission, Discharge and Appeals” notice is delivered to the member within the appropriate timeframe. CMS views lack of documentation as an indication that the member never received the proper notification, resulting in an increased probability of an overturn of the appeal at the CHDR level.
Member Appeals

Peer Review Organization (PRO) Immediate Review of Hospital Discharges (cont.)

If the member thinks they are being asked to leave the hospital too soon, they have the right to request a review by a Peer Review Organization (PRO). PROs are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness, and quality of hospital treatment furnished to Medicare patients, including those enrolled in a managed care plan. Members are not responsible for payment of their hospital care until the PRO makes its decision, if they request review by noon of the first workday after they receive the notice of explanation. Members have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of the illness or injury. According to federal law, their discharge date must be determined solely by their medical need.

If members request immediate review by the PRO within the allotted timeframe, they are entitled to this process instead of PacifiCare’s Appeals Process – not both. They may appeal PacifiCare’s notification, within 60 days of the notice, by requesting that PacifiCare reconsider its decision. The advantage of the PRO review is that the member will get the results within three days if they request the review on time. Also, members are not financially liable for hospital charges during the PRO review.

Note: Members may file an oral or written request for an expedited/72-hour appeal only if they have missed the deadline for requesting the PRO review. Members should specifically state that they want an expedited appeal or 72-hour appeal or that they believe their health could be seriously harmed by waiting for a standard appeal.
Member Appeals

PRO Quality of Care Complaint Process

If members are concerned about the quality of care they have received, they may file a complaint with the Peer Review Organization (PRO) in their local area.

Grievance Procedure

PacifiCare will attempt to resolve any complaint that the member might have. We encourage the informal resolution of complaints (i.e., over the telephone), especially if such complaints result from misinformation, misunderstanding or lack of information. However, if the complaint cannot be resolved in this manner, a more formal member grievance procedure is available.

PacifiCare Members have the right to file a complaint - also called a grievance – about problems they observe or experience including:

- Complaints about the quality of services received

- Complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar Member concerns

- Involuntary Disenrollment situations

- If the member disagrees with PacifiCare’s decision to process their prior authorization request under the standard 14 day timeframe rather than expedited/72-hour timeframe

- If the member disagrees with PacifiCare’s decision to process their appeal request under the standard 30 day timeframe rather than expedited/72-hour timeframe
Member Appeals

Hospital Responsibilities

The Hospital and Hospital Providers will assist PacifiCare in the handling of member complaints, grievances and appeals, consistent with the member Appeals and Grievance procedures.
## Section F:

### Provider Disputes

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Section F: Provider Dispute Resolution

**Submission Requirements**

**Provider Disputes**

PacifiCare’s dispute resolution procedure is available to provide a fair, fast and cost-effective resolution of provider disputes. The Provider Dispute Resolution Procedure is **not** intended to provide a mechanism for renegotiating the terms of the provider agreement. It is a mechanism by which contracting providers may submit disputes arising out of the performance or non-performance of the provider agreement. For non-contracting providers, the process may be utilized to submit issues related to billing and claims disputes. The following guidelines apply to all provider disputes submitted for review:

**Submitting Disputes**

The provider of service should submit any request to review a dispute in writing with the following information:

- Clear rationale or reason for contesting the determination.
- The PacifiCare member’s name
- The PacifiCare member’s Identification number
- The specific item in dispute.
- The rationale/reason why the dispute should be paid or approved.
- Copies of all relevant information, supporting documentation, required to review the providers concerns, (ex: claims, medical records, authorizations, etc).
- In the case of a delegated claim, a copy of the delegated payor’s, provider dispute resolution determination.

The provider should submit dispute requests to:

PacifiCare of California  
Provider Dispute Liaison  
Provider Operations  
P.O. Box 6006  MS CY22-369  
Cypress, CA  90630

**Processing a dispute**

Upon receipt of a dispute PacifiCare will:

- Send the provider a written acknowledgement of receipt of the dispute within the 15 working days of the receipt of the request for paper submissions.
- Conduct a thorough review of the provider’s request and all supporting documentation.
- Supply the provider with a written determination including the specific rationale for the decision within 45 working days of receipt.
Excluded from Provider Dispute

The following are examples of issues that are excluded from the provider dispute process.

- If a member has filed an appeal and a provider has filed a dispute regarding the same issue, the member’s appeal will be processed first. If the provider is appealing on behalf of the member, the appeal will be processed as a member appeal.

- An Independent Medical Review initiated by a member through the Member Appeals Process does not qualify for the Provider Dispute Resolution process.

- Any delegated claim issue that has not been reviewed through the delegated payors dispute resolution mechanism.

- Any dispute filed outside of the 180 calendar timely filing limit, who fails to supply “good cause” for the delay.

Timely Filing of Disputes

All disputes must be submitted within 180 calendar days following the date of the initial denial or payment.
Section G: Claims Processing

Claims Submission and Reimbursement Processing

Definition of Terms
- Clean Claims
- Complete Claim
- Contracted Basis of Payment and Reimbursement Rates
- Copayment
- Covered Services
- Deductible
- Hospital Services Agreement
- Managed Care Plan
- Medically Necessary Services
- Member
- Non-Clean Claims
- Non-Contracted Services
- Non-Covered Services

Hospital Responsibilities
- Collection of Member Copayments and Deductibles
- Member Billing Standards
- Claims Completion Requirements
- Claims Submission Requirements
- Medicare+Choice (Secure Horizon) Submission Requirements
- Stop Loss (Reinsurance) Claims Submission Requirements
- Timely Filing Submission Requirements
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- Third Party Liability
- Coordination of Benefits (COB)

PacifiCare Responsibilities
- Claims Adjudication
- Level of Care Documentation and Claims Payment
- Service Provided to Ineligible Members
- Reciprocity Agreements
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- Inspection and Audit of Records and Facilities
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Claims Research and Resolution

Revision Date: 12/2002
Section G: Claims Submission and Reimbursement Processing

Definition of Terms

Claims Processing

To ensure timely and more accurate claims payment, PacifiCare, in accordance with State and Federal laws, regulations, and policies, has established claims processing guidelines.

It is the intent of PacifiCare to process all clean/complete claims received by Hospitals for rendered Covered Services to eligible PacifiCare Members in accordance with the terms of the Hospital Services Agreement and as mandated by State and Federal requirements.

The definitions and claims processing guidelines contained herein are, unless specifically indicated to the contrary, the same as those found in a Hospital’s Hospital Services Agreement.

PacifiCare reimburses contracted Hospitals in accordance with established contract rates and in accordance with stipulated compensation provisions. If the Hospital fails to submit claims as specified, PacifiCare reserves the right to deny payment for such claims.

Definition of Terms

Clean Claims

A clean claim is one that can be adjudicated as submitted, because it is complete in all aspects, including appropriate coding, itemization of rendered services, dates of service and contracted billed amounts. A clean claim is a claim that has no defect or impropriety (including lack of required substantiating documentation) or particular circumstances requiring special treatment that prevents timely adjudication.

Clean claim requirements include but are not limited to:

- PacifiCare Member name
- PacifiCare Member number
- Date(s) of service
- Diagnosis of patient (ICD-9)
- Description of services
- Charges for services
- Physician ordering service
Section G: Definition of Terms cont.

Claims Processing

Revision Date: 12/2002

**Definition of Terms (cont.)**

- PacifiCare’s Authorization Number (if applicable)
- Other insurance coverage (when applicable)
- Providers Federal tax I.D. and remit address

**Complete Claim**

A complete claim is defined as a claim or portion thereof which provides information necessary to determine payer liability.

**Contracted Basis of Payment and Reimbursement Rates**

Each Hospital contract (to include Letter of Agreement (LOA), Memorandum of Understanding (MOU) and Rider Agreements specific to an identified Medical Group/IPA), contain specific reimbursement rates and the basis for which the Hospital will be paid by PacifiCare.

**Copayment**

A Copayment is a fee that may be charged to Members for certain Hospital Services and collected by Hospital or its Hospital Providers at the time Hospital Services are provided, as set forth in the applicable Managed Care Plan

**Covered Services**

Include those Medically Necessary Services, supplies and benefits which are required by a Member as determined by Medical Group or PacifiCare in accordance with the Member’s Managed Care Plan and PacifiCare’s Quality Improvement Program and Medical Management Program. For purposes of this Manual, “Medically Necessary” shall have the meaning set forth in the applicable Subscriber Agreement and Evidence of Coverage.

**Deductible**

A deductible is the aggregate dollar amount, which an Eligible Person is required to pay or incur for Covered Services, pursuant to the applicable Plan, before the Payor becomes financially responsible for any Covered Services.
### Definition of Terms cont.

#### Claims Processing

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<td>Includes, but is not limited to, Letters of Agreement (LOA), Memorandum of Understandings (MOU), Interim Payment Agreements, Amendments to Existing Agreements between PacifiCare and Hospital, and any amendments, exhibits and attachments thereto.</td>
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#### Managed Care Plan

Include any one of the various health plans or products sponsored or administered by PacifiCare or its subsidiaries or affiliates including, without limitation, a commercial prepaid health plan (“PacifiCare Commercial Health Plan”), a commercial point-of-service plan (“PacifiCare Commercial POS Health Plan”), a commercial preferred provider organization plan (“PacifiCare Commercial PPO Plan”), and a Medicare + Choice plan (“Secure Horizons Health Plan”). Each Managed Care Plan is described in the applicable Subscriber Agreement. PacifiCare may make available some, and not all, of the Managed Care Plans.

#### Medically Necessary Services

Refers to Medical or Hospital Services which are determined by a medical director of PacifiCare or the Participating Medical Group to be; (i) rendered for the treatment or diagnosis of any injury or illness, (ii) appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with professionally recognized standards, which shall include consideration of scientific evidence, (iii) not furnished primarily for the convenience of the Member, the attending Physician or other Provider of services, and (iv) if more than one service, supply or level of care meets the requirements of (i) through (iii) above, furnished in the most cost-effective manner which may be provided safely and effectively to the Member.

“Scientific evidence” as referenced in section (ii) above, shall include peer reviewed medical literature, publications, reports, and other authoritative medical sources.

#### Member

A PacifiCare Member is an individual who is enrolled in a Managed Care Plan and meets all the eligibility requirements for membership in the Managed Care Plan and for whom the applicable premium has been received by PacifiCare.
**Claims Processing**

**Non-Clean Claims**

A non-clean claim is a submitted Hospital claim for which:
- additional information from an external source must be requested,
- the claim is missing key claim form requirements (as indicated above),
- the Claims Examiner is unable to identify whether the rendered service was appropriately authorized,
- the charges for rendered service do not match the basis of payments specified in the current Hospital Services Agreement and/or
- the claim was not submitted in accordance with the provisions set forth in the current Hospital Services Agreement.

**Non-Contracted Services**

Includes those services, which have not been identified in the contract between PacifiCare and Hospital.

**Non-Covered Services**

Include those services that are not stipulated in the Member’s Evidence of Coverage or Subscriber Agreement, health care services that have been determined to be not Medically Necessary, supplies and benefits which are not required by a Member (such as patient “convenience items”, etc.)
## Section G: Hospital Responsibilities

### Claims Processing

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<td>In order to expedite accurate payment of submitted clean claims, Hospital shall cooperate with PacifiCare in the accurate completion and submission of clean claims within the timeframe specified for Covered Services as described in this manual or the Hospital Services Agreement.</td>
<td>The Hospital is responsible for the collection of applicable Deductibles and or Copayments/Coinsurance in accordance with the Member’s Managed Care Plan. PacifiCare will automatically adjust prospective Hospital claims payments by deducting the applicable Member Copayment/Deductible(s) from the Contracted Basis of Payment and Reimbursement Rate. For Members who have a Copayment/Deductible that is based on a percentage of the cost of services provided, the Copayment/Deductible should be calculated based on the Contracted Basis of Payment and Reimbursement Rate. Contact the PacifiCare/Secure Horizons Voice Response Unit to verify the Copayment/Deductible. Commercial and Secure Horizons Members may have Copayments/Deductibles for emergency room services. Inpatient Copayments/Deductibles may also vary depending on the Managed Care Plan and service type. Member materials instruct the Member to pay their Copayments/Deductibles at the time of each visit. Emergency room Copayments/Deductibles may be collected at the time of the service, but if the Member is admitted, the emergency room Copayment/Deductibles is waived. If not paid at the time of service, Members may be billed for Copayments/Deductibles.</td>
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Section G: Claims Completion Requirements

Claims Processing

Revision Date: 12/2002

Claims Completion Requirements

1) Prior to initiating a hospital claim, hospital shall, to the best of its ability:

- identify whether payment for the claim is the identified responsibility of PacifiCare. Hospital shall refer to the applicable Division of Financial Responsibility (DOFR) in determining whether PacifiCare is responsible for Hospital claims payment,

- ensure that those Covered Services that are the responsibility of the Member’s Medical Group are adjusted out of any claim amount owed by PacifiCare,

- ensure that the patient receiving hospital services is an eligible Member,

- ensure that the hospital services rendered to the eligible Member were appropriately authorized by the Medical Group and/or PacifiCare Medical Management,

- ensure that the rendered hospital services were for Covered Services and

- collect applicable Copayments/Deductibles and appropriately adjust claims for Covered Services and Member.

2) In completing a hospital claim, hospital shall:

- utilize the most current service codes (i.e. ICD-9 and CPT-4 codes) to include appropriate beddays and or unit of service counts,

- ensure the documented bill type is appropriate for the type of service provided,

- utilize the appropriate billing form (i.e. UB-92, etc.) with all required corresponding patient, service and authorization information,
Section G: Claims Completion Requirements cont.

Claims Processing

Claims Completion Requirements (cont.)

- collect all applicable Member Copayments/Deductibles at the time care is rendered,
- bill for each Covered Service in accordance with Contracted Basis of Payment and Reimbursement Rates,
- submit claims at the Contracted Basis of Payment and Reimbursement Rates adjusted for applicable Member Copayments and/or Deductible, and
- submit applicable corresponding documentation (e.g. Hospital Invoices) as noted above or in accordance with the Hospital Services Agreement.

3) In addition, submitted Hospital claims shall identify:

- if a claim meets reinsurance criteria by indicating “Stop Loss” directly on the claim,
- excluded items billed at the Contracted Basis of Payment and Reimbursement Rates,
- other pertinent required medical treatment documentation in accordance with the terms of the Hospital Services Agreement, as required by PacifiCare’s Medical Director/Medical Management Department and/or as required by State or Federal Laws and Regulations.
Section G: Claims Submission Requirements

Claims Processing

Claims Submission Requirements

Hospital claims shall be submitted to PacifiCare on industry standard forms (HCFA 1500’s, UB92’s) and forwarded to the address listed on the eligible PacifiCare Member’s identification card.

If no identification card is available forward applicable claims to:

**HMO Claims**
PacifiCare of California
Attn: Commercial Claims
P.O. Box 6006
Cypress, CA 90630-6006

**Secure Horizons (Medicare + Choice) Claims**
Secure Horizons of California
Attn: Claims
P.O. Box 489
Cypress, CA 90630-0489

**PPO/POS, Non-Contracted Hospital and Out-Of-Area (OOA) Claims**
POS Claims – P.O. Box 6019
Cypress, CA 90630-0019
PPO Claims – P.O. Box 6035
Cypress, CA 90630-0035

Additional Claims Submission Requirements for Medicare + Choice (Secure Horizons) Members

For those Hospital claims submitted for Covered Services rendered to eligible Secure Horizons Members, additional requirements have been established by CMS (formerly known as HCFA).

The Balanced Budget Act of 1997 required several changes that affect the claims submission processes for all Medicare + Choice organizations. Effective January 2000, CMS initiated a phase-in plan to reimburse health plans based on the Member’s health status. CMS assigns each Member a Principle Inpatient Diagnostic Code Group (PIP-DCG) by reviewing the Principle Diagnostic Code (ICD9) of each qualifying inpatient encounter submitted for the Member during the reporting period. The UB92 is the only document CMS will accept to determine the PIP-DCG assignment.
Additional Claims Submission Requirements (cont.)

This new method of reimbursement requires Secure Horizons to send all payable claims to CMS for review. It is extremely critical that you submit complete and accurate UB92s to Secure Horizons in a timely manner. Once received by CMS, the claims must pass all the edits that are applied to fee-for-service UB92 bills.

In order to minimize rejected claims, the Hospital must manage and/or process their managed care claims in the same manner as their Medicare fee-for-service bills.

If the UB92 claims data does not pass the CMS edits, CMS will return the claim to Secure Horizons. Secure Horizons’ claims data staff will then contact the hospital billing department to obtain the correct or missing UB92 information for resubmission. Cooperation and quick turnaround time from the hospital in obtaining correct information is a must.

CMS may audit the health plan’s data submission at any time. The billing and Member medical information must be able to be tracked back to the source document; the original UB92 submitted by the hospital. Only the rendering hospital may change the original UB92 or submit a new UB92. Compliance on the hospital’s part is needed in order for health plans to submit the correct data.

Claims Submission Requirements for Stop-Loss (Reinsurance) Claims

Should contracted Covered Services fall under the Stop-Loss Provisions set forth in the Hospital Services Agreement, Hospital shall abide by the terms of the Agreement in ensuring that:

- the stipulated threshold has been met,
- only Covered Services are included in the computation of the stop-loss threshold,
- only those Inpatient Services specifically identified under the terms of the Stop-loss Provision(s) may be used to calculate the stipulated threshold rate,
Section G: Claims Submission Requirements cont.

Claims Processing

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Claims Submission Requirements for Stop-Loss (cont.)

- applicable eligible Member co-payments and or Deductible amounts are deducted from the stop-loss threshold computation,

- the stipulated stop-loss conversion reimbursement rate is applied to all subsequent Covered Services and submitted claims,

- the stop-loss is applied to the specific authorized acute care confinement

- submitted in accordance with the stipulated timeframe, if any, as stipulated in the Hospital Services Agreement.

In addition, when submitting hospital claims that have reached the contracted Stop-loss Provisions and are being billed in accordance with the terms stipulated in the Hospital Services Agreement and/or this Manual, the Hospital shall:

- indicate if a claim meets reinsurance criteria (to include but not limited to, by stamping “Stop Loss” directly on the paper claim),

- make Medical records available upon request for all related services identified under the Stop Loss Provisions (i.e., ER face sheets).

If a submitted hospital claim does not indicate that the claim has met the contracted reinsurance criteria, PacifiCare shall continue to process the claim at the stipulated appropriate LOC per diem rate.
### Section G: Timely Filing Claims Submission

#### Claims Processing

| **Timely Filing Definition** | The claims “Timely Filing Limit” is defined as the calendar day period between the claim’s last date of service, or payment/denial by the primary payer, and the date by which PacifiCare must first receive the claim.  
The “Received Date” is the oldest PacifiCare date stamp on the claim. Acceptable date stamps include any of the following:  
- PacifiCare HMO Claims department date stamp,  
- Primary payer claim payment/denial date |
| **Initial Claim Timely Filing Limit** | The claim’s initial timely filing limit is 90 calendar days, or as defined in the Service Agreement. The Medical Group/IPA or hospital is responsible to submit all claims to PacifiCare within the specified timely filing limit.  
PacifiCare or its delegated representative may deny any claim billed by the provider that is not received within the specified timely filing limit. |
| **Coordination of Benefits (COB) Claim Timely Filing** | The COB claims filing limit is established as the 90-calendar day period, between the date of payment or denial by the primary payer.  
PacifiCare or its delegated representative may deny any claim billed by the provider that is not received within the specified timely filing limit. |

*The timely filing limit will be updated according to any relevant changes in legislation.*
### Section G: Submission of Payable Claims via Electronic Data Interchange

**Claims Processing**

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| Submission of Payable Claims via Electronic Data Interchange | 
|---|---|
| Electronic Data Interchange (EDI) is a term that describes the process of transmitting information, in a specific format, from one computer to another. EDI helps you and PacifiCare/Secure Horizons maintain a flow of vital information by enabling the electronic transmission of claims and managed care transactions. Using EDI you can send payable HCFA-1500 or UB92 medical claims to PacifiCare/Secure Horizons using your computer. | 

**Benefits of EDI**

EDI delivers a wide array of benefits for healthcare providers. It eliminates the need for your office staff to prepare claims manually or re-key repetitive transaction information. In fact, by using EDI, you can eliminate paper forms, envelopes and stamps. Your staff will be able to work more efficiently on other important matters, saving the office both time and money.

With EDI, claims are processed quickly, efficiently and accurately. Fewer rejected claims mean better cash flow for your practice. There is no minimum amount of claims needed in order to submit electronically to PacifiCare/Secure Horizons.

**PacifiCare/Secure Horizons and EDI**

PacifiCare/Secure Horizons can accept payable claims from hospitals, groups or individuals using the National Standard Format (NSF) version 3.01 for HCFA-1500 and UB92 version 5.0 for the UB92.

EDI encounters are collected using a different submission procedure and therefore can not be submitted through the payable EDI process. EDI payable claims are accepted for PacifiCare/Secure Horizons HMO, POS, and PPO product lines. Inquiries for all electronic submissions should be directed to 1-800-203-7729.

**EDI Payable Claims Submission Methods**

1. **Clearinghouse Connections**

   PacifiCare/Secure Horizons accepts EDI transmissions from multiple clearinghouses. Contact your preferred clearinghouse directly to determine their connectivity to PacifiCare/Secure Horizons or their ability to create a new EDI connection. Using a clearinghouse may help ensure a smooth transition to the forthcoming EDI requirements outlined in the Health Insurance Portability and Accountability Act (HIPAA).

   If the clearinghouse you choose has never billed PacifiCare/Secure Horizons before, we will need to coordinate an EDI claims test with them. Please have the clearinghouse contact the EDI General Information Line at 1-800-203-7729 to set up testing.
## Section G: Submission of Payable Claims via Electronic Data Interchange

### Claims Processing

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<table>
<thead>
<tr>
<th>EDI Payable Claims Submission Methods</th>
<th>1) Clearinghouse Connections continued</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you are required to test your internal claims system with your clearinghouse, the test must be performed and completed prior to EDI claims submissions. Once you have successfully completed your test with the clearinghouse, they will notify you when you may begin submitting electronically.</td>
</tr>
<tr>
<td></td>
<td>All submitters are required to separate payable claims data from encounter data. If you do not know how to separate your claim and encounter data, contact your software vendor.</td>
</tr>
<tr>
<td></td>
<td>All electronic claims must be submitted with a Payer ID number so the clearinghouse know where to send the claim. The Payer ID for PacifiCare/Secure Horizons HMO and in-network POS claims is <strong>95959</strong> (this number is for California, Washington and Oregon’s payable claim and should NOT be used for encounter data submissions). The Payer ID for PPO and out-of-network POS is <strong>95999</strong>.</td>
</tr>
<tr>
<td></td>
<td>Place the payable Payer ID Number in the following format locations. If you do not know how to do this, contact your software vendor for details:</td>
</tr>
<tr>
<td></td>
<td>- If using file format NSF 3.01: place the payable claim Payer ID in record AA0, field 17, position 227–242 and record ZA0, field 4, position 29 - 44.</td>
</tr>
<tr>
<td></td>
<td>- If using file format UB92 5.0: place the payable claim Payer ID in record 01, field 6, position 32-36 and record 99, field 3, position 13 -17.</td>
</tr>
<tr>
<td></td>
<td>2) <strong>Direct Connections</strong></td>
</tr>
<tr>
<td></td>
<td>PacifiCare/Secure Horizons also accepts EDI transmissions directly. Direct EDI submissions are accepted via secure File Transfer Protocol (FTP), diskette, CD-R or tape. Please note that if you choose to use one of these direct submission methods, you will be responsible for updating your EDI transmissions to conform to the forthcoming HIPAA’s EDI requirements outlined by the ASC X12N 837 (004010X096).</td>
</tr>
</tbody>
</table>
Section G: Submission of Payable Claims via Electronic Data Interchange

Claims Processing

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EDI Payable Claims Submission Methods continued

2) Direct Connections continued

As a direct submitter of EDI, you will be required to send a test file of claims to PacifiCare/Secure Horizons prior to full claims processing implementation. Test files must consist of sample data that is consistent with your specialty and practice. Old payable claim data is especially good to use for test purposes. Your test data file must be submitted to us via diskette or CD-R. Test data must be less than 1MB in size and must meet the acceptable data formatting standards. As a reminder, we accept data formats NSF version 3.01 or UB92 version 5.0. *No other formats are accepted at this time, including the ASC X12N 837 (004010X096).*

When choosing to submit payable EDI claims directly to PacifiCare/Secure Horizons, the testing process will take approximately two to three weeks. Testing time depends on your office and system capabilities. PacifiCare/Secure Horizons will notify you of your EDI test results. We will also inform you of the date when you may begin submitting EDI claims in the production mode.

If you wish to submit EDI claims directly to PacifiCare, please send your electronic test claim data file, with a cover letter containing your office information to:

PacifiCare Claims Department
Attention: EDI TEST
Mail Stop CY38-101
10700 Valley View St
Cypress, CA 90630-4835

Your EDI Next Step

Whether you choose to use a clearinghouse or submit EDI claims directly, the process is easy. For clearinghouse EDI claims submission, contact your clearinghouse directly. They will provide all the necessary testing and submission information that you will need. For submitting EDI claims directly to PacifiCare/Secure Horizons contact the EDI General Information line at 1-800-203-7729.
Section G: Submission of Payable Claims via Electronic Data Interchange

Claims Processing

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**General Submission Guidelines**

- All claims and encounters data should be submitted using the unique PacifiCare/Secure Horizons nine (9) digit member ID. Data submitted with a Social Security Number (SSN) as the member identification, may result in unnecessary delays or claims rejections.
- All claims determined to be the administrative responsibility of the member’s assigned medical group will be rejected as a “Group Return”. Please ensure that submitted EDI claims are indeed the financial responsibility of PacifiCare/Secure Horizons.

Listed in the following table are services that have typically required additional information. Please note the “Requirement” field for items that, if met through EDI, may eliminate a separate submission for additional information. These services are (may include other claim types not listed):

<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
<th>Claim Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility claims</td>
<td>Specific level of care, rate and Part B service information</td>
<td>“Information Faxed”</td>
</tr>
<tr>
<td>Chemotherapy Claims</td>
<td>National Drug Code (NDC)</td>
<td>NDC number listed</td>
</tr>
<tr>
<td>Dialysis Claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Injectables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of Area/Out of Network Claims</td>
<td>Facility Address with Zip Code (to determine payment responsibility)</td>
<td>Facility Address with Zip Code listed</td>
</tr>
<tr>
<td>Ambulance Claims</td>
<td>Zip Codes/ To &amp; From Addresses (to determine mileage for appropriate claims processing)</td>
<td>Zip Codes/ To &amp; From Addresses</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>Other insurance information:</td>
<td>Indicate other insurance information or “COB Information Faxed”</td>
</tr>
<tr>
<td>- Name of Other Insurance Company</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Policy Number(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Group I.D. Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Effective Date of Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other Carrier’s Insured Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other Carrier’s Insured Relationship to the PacifiCare member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient claims over $40,000 at billed charges</td>
<td>Itemized Statement</td>
<td>Description of items or “Itemized Statement Faxed”</td>
</tr>
<tr>
<td>Transplant cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusionary items not identified by a specific revenue code</td>
<td>Detailed description</td>
<td>“Information Faxed”</td>
</tr>
<tr>
<td>Exclusionary items payable at cost or percentage of billed charges</td>
<td>Invoice and detailed description</td>
<td>“Information Faxed”</td>
</tr>
</tbody>
</table>
Section G:  Submission of Payable Claims via Electronic Data Interchange

Claims Processing

If additional information is necessary to process your claim, it must be submitted separately from the electronic claim:

1. Indicate appropriate comments in the “Comments” field:
   - NSF v. 3.01: in the FA0 field, insert specific comments under the corresponding HA0 record, one detail comment per line (box 24 on the form).
   - UB92 v.5: in record 90 field 17 (box 84 on the form).

2. Submit the claim(s) electronically

3. On your documentation include all of the following:
   - The words “EDI Additional Information” as the header for your fax sheet.
   - Patients full name
   - PacifiCare/Secure Horizons membership number
   - Procedure code(s)
   - Provider Name (as it appears on the electronic claim)
   - Date of service(s)
   - EDI Transmission Date
   - EDI Additional Information Transmission Date
   - Page X of Y

Within 24 hours of transmitting your electronic claim, fax your additional documentation to (888) 360-0755. If unable to send via facsimile, please submit the additional claim information on paper to:

PacifiCare Claims Department
Attention: Additional Information
Mail Stop CY38-174
P.O. Box 6006
Cypress, CA 90630-4835
Section G: Third Party Liability

Claims Processing

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Third Party Liability

If a Member is entitled to payment from a third party, PacifiCare assigns to the Hospital for collection, any claims or demands against such third parties for amounts due for Hospital Services, subject to the following conditions:

- Hospital shall utilize lien forms which are approved in advance by PacifiCare, to the extent liens are utilized
- Hospital is required to notify PacifiCare each time it pursues and each time it obtains a signed lien from a Member
- Hospital shall not commence any legal action against a third party without obtaining the written consent of PacifiCare
- For those Hospitals who have been delegated claims payment responsibility, Hospital shall make no demand upon PacifiCare for reimbursement until all third party claims have been pursued and it is determined that full payment cannot be obtained within 12 months from the date of the hospital service
- PacifiCare may immediately rescind the assignment of any or all claims and demands against third parties by providing written notice of rescission to the Hospital
- In the event that Hospital receives payment from a third party after receipt of payment from PacifiCare, Hospital is required to reimburse PacifiCare to the extent that the combined amounts received from all parties exceeds the amounts set forth in the Hospital contract.

Coordination of Benefits (COB)

If a Member has health benefits coverage through another policy that is primary to PacifiCare the Hospital may pursue payment from the primary payor.

PacifiCare’s responsibility as a secondary payor shall not exceed the amounts documented in the Hospital Services Agreement less all amounts paid by the Primary Payor.

PacifiCare adheres to the National Association of Insurance Commissioners (NAIC) Model Rules and Medicare Billing Rules in the determination of the order of benefits to appropriately manage those instances in which a PacifiCare Member has more than one health insurance carrier.
Section G: Third Party Liability
PacifiCare Responsibilities

Claims Processing

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Coordination of Benefits (COB) cont.

If a Member has health benefits coverage through another policy that is secondary to PacifiCare, the Hospital is required to accept payment from PacifiCare for hospital services as payment in full, except for applicable Copayments. The Member has no obligation for any fees, regardless of whether the secondary insurance is available.

PacifiCare Responsibilities

For each “Clean Claim” submitted to PacifiCare by the Hospital, PacifiCare will pay the Contracted Basis of Payment and Reimbursement Rate due to the Hospital as specified in the Hospital Service Agreement.

Claims Adjudication

PacifiCare shall use established industry claims adjudication and/or clinical practices, State and Federal guidelines, and/or PacifiCare policies, procedures and data to determine appropriate basis of payment. These sources include but are not limited to:

- established Secure Horizons, PacifiCare and/or Subscriber Group Listings to determine Member eligibility,
- established Member Evidence of Coverage, and/or Schedule of Benefits to determine Covered Services,
- established CMS Correct Coding Initiative (CCI) Billing Rules,
- established CMS Multiple Procedure Billing Rules,
- established CMS Bundling/Unbundling Billing Rules,
- established Clinical Review Sources (to include Inter-Qual) to determine medical necessity and LOS,
- established Federal Food and Drug Administration definition for the determination of designated implantable surgical devices and/or implantable orthopedic devices,
- established and most current approved ICD-9, UB, DRG, CPT, HCPCS, and
- established Basis of Payment and Reimbursement Rates stipulated in the Hospital Services Agreement then current on the Member’s first day of confinement and or on date the Covered Service was rendered.
Hospital claims adjudicated by PacifiCare which are determined to contain billing errors will be considered Non-Clean Claims and may be returned to Hospital for correction.

In addition, in order to ensure accurate payment of submitted clean claims, PacifiCare shall:

- utilize Claims Re-Pricing Vendor(s) for the purpose of determining accurate basis of payment and reimbursement rates,

- conduct routine audits of paid claims to determine:
  (i) Overpayments to Hospital,
  (ii) Underpayments to Hospital,
  (iii) Hospital Billing Error Trends,
  (iv) Potential Fraudulent Billing Practices and
  (v) Required improvements/modification/amplifications to existing Hospital Service Agreement Contracted Basis of Payment and Reimbursement Rates.

- Refer specific claims to Clinical Review Staff for the purpose of:
  (i) certifying provided LOC,
  (ii) identifying variances between the authorized LOC provided versus the billed rate LOC,
  (iii) identifying potential clinical documentation errors and/or billing fraud, providing process and/or clinical improvements for enhanced management of claims management.

PacifiCare captures level of care (LOC) for all types of inpatient and skilled nursing facility admissions. The appropriate PacifiCare staff reviews the documented LOC at admission and LOC changes throughout the subsequent stay.

In turn, PacifiCare processes claims according to the authorized LOC documented in the authorization record, reviewing all claims to determine if billed LOC matches authorized LOC. In addition, PacifiCare shall:

- Pay only the authorized LOC, if the billed LOC is at a higher level than the LOC authorized by PacifiCare

- Pay the lesser of the billed charges, if the billed LOC is at a lower level than the LOC authorized by PacifiCare
Services Provided to Ineligible Members

In the event that PacifiCare provides information that indicates that a Member is eligible at the time services are provided and it is later determined that the Member was not in fact eligible, PacifiCare will not be responsible for payment of services provided to the Member regardless of whether the service was authorized.

In such event, the Hospital is entitled to collect the payment directly from the Member (to the extent permitted by law) or from any other source.

Reciprocity Agreements

Hospital shall cooperate with PacifiCare’s Participating Providers and other PacifiCare-affiliated entities (“PacifiCare Affiliate(s)”) and agrees to provide Hospital Services to Members enrolled in Managed Care Plans and programs of PacifiCare Affiliates and to assure reciprocity of providing health care services.

Without limiting the foregoing, if any Member who is enrolled in a Managed Care Plan, or program of any PacifiCare Affiliate receives services or treatment from Hospital or its Hospital Providers, Hospital or the Hospital Provider agrees to bill the PacifiCare Affiliate at billed charges and to accept the compensation provided pursuant to this Agreement, less applicable Copayments, Deductible, and/or Deductibles, as payment in full for such services or treatment.

Hospital shall comply with the procedures established by PacifiCare or the PacifiCare Affiliate and this Agreement for reimbursement of such services or treatment.

Recoupment Rights

Except as may otherwise be specifically provided in the existing Hospital Services Agreement, PacifiCare shall have the right to immediately recoup any and all amounts owed by Hospital to PacifiCare against amounts owed by PacifiCare to Hospital. PacifiCare’s rights shall include, without limitation, PacifiCare’s right to recoup the following amounts owed to PacifiCare by Hospital:

- amounts owed by Hospital due to overpayments or payments made in error by PacifiCare,

- amounts owed by Hospital due to receipt of payments made by Members to Hospital for Covered Services, excluding Copayments, deductibles, and co-insurance,
Recoupment Rights cont.

As a material condition to PacifiCare’s obligations under the Hospital Services Agreement, Hospital agrees that all recoupment and any offset rights pursuant to this Agreement shall be deemed to be and to constitute rights of recoupment authorized under State or Federal Law or in equity to the maximum extent possible under law or in equity and that such rights shall not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Hospital. Pursuant to PacifiCare’s established Provider Dispute Resolution Procedures, Hospital may dispute any recoupment by PacifiCare described in this Manual.

Request for Reimbursement

In the event PacifiCare identifies an overpayment of a claim, the following will occur:

A request for reimbursement for any overpayment of a claim must be completed in compliance of State and Federal regulations and must be completed utilizing the following guidelines:

- Request must provide a clear, accurate, written explanation.
- Request must be issued within 180 calendar days from the date of payment.
- The provider must be given information on the right to contest the notice.

Adequacy of Compensation

Hospital agrees to accept payment as provided herein as payment in full for providing rendered Covered Services, whether that amount is paid in whole or in part by Member, PacifiCare or any Subscriber, including other health care plans that pay before PacifiCare as required by applicable state or federal coordination of benefits provisions.

This Manual does not prohibit Hospital from collecting applicable Copayments, Deductible, or deductibles consistent with the Managed Care Plans.
Section G: Payments Following Termination of Agreement

No Billing of Members (Hold Harmless)

Inspection and Audit of Records and Facilities

Claims Processing

Revision Date: 12/2002

Payments Following Termination of Agreement
Following termination of the Agreement and until the expiration of the continuity of care period provided in Section 8.3 of the Agreement, PacifiCare shall compensate Hospital for Hospital Services provided to Members under the same terms and conditions which applied prior to termination of the Agreement.

No Billing of Members (Member Hold Harmless Provision)
With the exception of copayments and charges for non-covered services delivered on a fee-for-service basis to Members, Hospital shall in no event, including, without limitation, non-payment by PacifiCare, insolvency of PacifiCare, or breach of an existing PacifiCare Hospital Services Agreement, bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from, or have any recourse against any Member or any person (other than PacifiCare) acting on behalf on any Member or attempt to do any of the foregoing for Hospital Services provided pursuant to the Agreement.

Inspection and Audit of Records and Facilities
Hospital shall provide access at reasonable times and upon request by PacifiCare (to include PacifiCare’s Claims and Audit contracted Vendors), Accreditation Organizations and Government Agencies to periodically audit or inspect the facilities, offices, equipment, books, documents and records of Hospital and its Hospital Providers relating to the performance of contracted hospital services and the Covered Services provided to Members, including, without limitation:

- all phases of professional and ancillary medical care provided or arranged for Members by Hospital and its Hospital Providers,

- Member medical records and financial records pertaining to the cost of operations and income received by Hospital received from PacifiCare for Covered Services rendered to Members.
Section G: Inspection and Audit of Records and Facilities

Medicare Opt-Out Providers

Claims Processing

Revision Date: 12/2002

Inspection and Audit of Records and Facilities Cont.

- Hospital and its Hospital Providers shall retain the books and records described in this Section for at least six (6) years and acknowledge that certain Government Agencies may have the right to inspect and audit Hospital’s books and records following termination of a current Hospital Services Agreement.

- The provisions of this Section shall survive termination of this Agreement for the period of time required by State and Federal Law.

Medicare Opt-Out Providers

PacifiCare abides by and requires its Hospital Providers to abide by Medicare’s physician/practitioner opt-out policy. Physicians/Practitioners who opt-out of Medicare (this may include Physicians/Practitioners not participating in Medicare) are not allowed to bill Medicare or its Medicare+Choice plans for two years from the date of official opt-out. PacifiCare and its delegated entities will not contract with or pay claims to providers who have opted-out of Medicare for Secure Horizons membership.

Exception: In an emergency or urgent care situation a physician/practitioner who opts-out of Medicare may treat a Medicare beneficiary with whom he/she does not have a private contract and bill for such treatment. In such a situation the physician/practitioner may not charge the beneficiary more than what a non-participating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary’s behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with the physician/practitioner.
Section G: Claims Research and Resolution

Claims Processing

The purpose of the Claims Research & Resolution process is to research and resolve capitated claims issues. Claims inquiries may come from members who are receiving bills, or from providers of service who have not received payment for rendered services. When a member receives a bill and contacts the plan we will research with the payer who holds financial risk and abide by Federal and State Legislation on appropriate timelines for resolution.

When a provider of service contacts the plan prior to initiating research and resolution through PacifiCare the provider of service must have billed and/or appealed to the appropriate payer.

PacifiCare must resolve all member complaints within 30 days, in accordance with NCQA guidelines and State and Federal legislation. Once a claim has generated a complaint from the member, it becomes an urgent issue within the PacifiCare organization.

The process below outlines the steps each Claims Research & Resolution Associate will follow as he/she works through the process of resolving claims issues:

- A claims inquiry, from a provider or a member, is directed to the Claims Research and Resolution department.
- The Research Associate will verify the following:
  - Member eligibility
  - Billed services are a covered benefit
  - The claim meets the payable criteria
  - Which contracted entity is financially responsible for the claim
- The Associate will contact the provider of service to verify that the claim has been billed correctly and to obtain a copy of the claim, if necessary.
- The Associate will contact the entity determined to be the payer to verify they have the claim on file.
- The Associate will verify the authorization or referral status.
Claims Research and Resolution (continued)

- The claim is then faxed to the payer for a 14-calendar day response of status or payment agreement (5 days for urgent cases).

- After two attempts to determine status or payment, with no response or when a payment arrangement agreement has been negotiated and defaulted on, PacifiCare will issue payment to the provider of service and pursue capitation deduction to recoup any monies paid on behalf of the Medical Group/IPA/Hospital.

- Verification of the claims research process and the appointed contact will be reviewed during a claims audit.

Capitated Claims inquiries received from providers are handled by our Capitated Claims Project Team, a small subset of Claims Research & Resolution.

Providers within the PacifiCare network are responsible to bill their claim(s) to the appropriate delegated entity who holds financial responsibility to process such claims.

Those providers who hold direct contract relationships with such delegated entity are also obligated to work with their contracted partner to resolve any disputes that should arise from the contractual relationship.

Both contracted and non-contracted providers should direct any claims disputes (for both unpaid and underpaid claims) initially to the party responsible to process the claim. If the provider of service is dissatisfied with the results from these efforts, PacifiCare allows its provider network to dispute directly to PacifiCare for resolution.

PacifiCare will assist providers in the resolution of such claims in accordance with the capitated provider’s contractual terms and in compliance with any pertinent regulatory statutes or regulations.

For additional information on the Provider Dispute mechanism, please refer to Section F, “Provider Disputes”.
### Duplication of Coverage

#### COORDINATION OF BENEFITS – GENERAL INFORMATION

- **PacifiCare as Primary Payor**
- **PacifiCare as Secondary Payor**

#### COORDINATION OF BENEFITS - MEDICARE

- **Champus**

#### WORKERS’ COMPENSATION

- **Lien Forms**
- **Notification**
- **Legal Action**
- **Claims Submission**

#### FIGURES H-1 THROUGH H-3

- **Figure H-1** Accident Questionnaire
- **Figure H-2** Notice and Allowance of Lien
- **Figure H-3** Notice of Reimbursement Rights

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Hospital Policy & Procedure Manual (Per Diem)
Original Date: 02/01/00
Revision Date: 11/01/01
## Coordination of Benefits – General Information

### Coordination of Benefits

Coordination of Benefits (COB), also referred to as non-duplication of benefits, is the practice of two or more plans coordinating their provision of health benefits to members who have multiple coverage.

COB regulations were developed by the National Association of Insurance Commissioners (NAIC), and adopted by various state HMO regulators and Departments of Insurance.

Currently, all of the health benefits provided by PacifiCare are subject to the COB provision.

### PacifiCare as Primary Payor

If a member has health benefits coverage through another policy which is secondary to PacifiCare under applicable Coordination of Benefits rules, including the Medicare secondary payor program, the hospital will:

- Accept payment from PacifiCare at rates set forth in the Hospital Agreement as payment in full except for applicable copayments, co-insurance, and deductibles.

### PacifiCare as Secondary Payor

If a member has health benefits coverage through another policy which is primary to PacifiCare under applicable Coordination of Benefits rules, including the Medicare secondary payor program, or if the member is entitled to payment under a workers’ compensation policy or automobile insurance policy, the hospital may pursue payment from the primary payor or workers’ compensation carrier consistent with the applicable laws and regulations.

PacifiCare, as the secondary payor:

- Will not exceed the lesser of:
  - The amounts as established in the Hospital Services Agreements less all amounts owed to the hospital by the primary payor
  - OR, the member’s out-of-pocket expense for the covered service.
Coordination of Benefits – Medicare (cont.)
End Stage Renal Disease

Duplication of Coverage

Coordination of Benefits - Medicare

Under some circumstances, Secure Horizons’ benefits will be secondary to those medical benefits to which a member is entitled, regardless of the members’ enrollment status with Medicare. Should the cost of medical or hospital services exceed other coverage, Secure Horizons’ benefits will be provided (as secondary coverage) up to Secure Horizons' liability.

Other coverage is primary over Secure Horizons in the following instances:

- **Aged Employees**
  
  For members who are entitled to Medicare due to age, Secure Horizons is primary over Medicare if the employer group has 20 or more employees.

- **Disabled employees (Large Group Health Plan)**
  
  For members who are entitled to Medicare due to disability, Secure Horizons is primary to Medicare if the employer group has 100 or more employees.

End Stage Renal Disease

If a member has (or develops) end stage renal disease (ESRD) while covered under an employer’s group plan, they must use the benefits of that plan for the first thirty (30) months after becoming eligible for Medicare based on ESRD. Medicare is the primary payor after this coordination period. (However if the employer group plan coverage was secondary to Medicare when the member developed ESRD because it was not based on current employment as discussed above, Medicare continues to be primary payor.)
Section H: CHAMPUS

Workers’ Compensation

Duplication of Coverage

CHAMPUS

PacifiCare benefits are primary to those in which a member is entitled under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS pays secondary to all other health insurance plans, except for Medicaid (public assistance). In the case of PacifiCare, CHAMPUS eligibility normally ends upon Medicare eligibility and therefore, no coordination takes place.

Workers’ Compensation

Workers’ Compensation has primary responsibility for payment in all compensatory work related injuries or illnesses. PacifiCare will not furnish benefits to any member which duplicate the benefits to which a member is entitled under Workers’ Compensation law. PacifiCare can divert the provision of care to an industrial clinic (if required by an employer) or the cost of care to an employer's Workers' Compensation carrier or benefits administrator, where liability under that system has been confirmed.

In the event PacifiCare (for reasons such as a pending Workers' Compensation Appeals Board care) provides benefits which duplicate those under Workers' Compensation, the member is required to reimburse PacifiCare, or its nominee, for the cost of all related services and benefits provided, upon obtaining a monetary recovery whether due to settlement or judgment. (For more information, see Lien Procedures under Third Party Reimbursement within this section.)
Duplication of Coverage

Third Party Reimbursement

If a member is entitled to payment from a third party (excluding a workers’ compensation carrier or primary insurance carrier under applicable Coordination of Benefits rules), the Hospital, as documented in the Hospital Services Agreement, is responsible for any claims or demands against the third party for amounts due for hospital services.

Lien Forms

Lien forms utilized by the hospital in the collection of any third party reimbursement must:

- Be approved in advance by PacifiCare
- OR, the hospital must use PacifiCare’s standard lien forms

Notification

The hospital must notify PacifiCare each time it pursues and obtains a signed lien form from a member.

Legal Action

The hospital will not commence any legal action as it relates to the Hospital Services Agreement against a third party without obtaining the prior written consent of PacifiCare.

Claims Submission

For all claims submitted to PacifiCare, the hospital is required to provide the name and basis for any known third party liability. The hospital must not demand payment from PacifiCare while pursuing payments from a third party.

PacifiCare has the right to pursue payment from any applicable third party when the hospital elects to submit the third party claim to PacifiCare for payment.

Should the hospital receive payment from the third party after receipt of payment from PacifiCare, the hospital will:

- Will notify PacifiCare in writing of the payment
- AND, will reimburse PacifiCare to the extent that the combined amounts received from all parties exceeds the amounts established in the Hospital Services Agreement
Duplication of Coverage

Figures H-1 through H-3
SAMPLE ACCIDENT QUESTIONNAIRE

Date

Injured Party
Member Number
Date of Occurrence

Dear:

In order to update our records and complete claims processing we are asking that you complete this questionnaire concerning your injuries and return it within 10 days. Enclosed is a postage paid envelope for your convenience.

Thank you for assisting our efforts in providing quality service.

Briefly describe cause of injury: (e.g., location of accident/how it happened) 

Name of other Insurance Company (e.g., auto, homeowners, workers comp)

Insurance Company Address:

Policyholder’s Name: Policy No.: Claim No.: 

If you have retained an attorney, please provide the following information:

Attorney’s Name:

Address: City: State: Zip:

Telephone No: FAX: 

Identity of other parties who may be responsible for the injuries:

Name: Telephone No: 

Address: City: State: Zip:

Name of Insurance Company:

Insurance Company Telephone No: FAX: 

Figure H-1 Accident Questionnaire
Duplication of Coverage

Insurance Company
Address: _______________________________________________________

City: __________________________ State: ________ Zip: ____________

Policyholder's Name: ____________________ Policy No: ________________

Adjuster's Name: ______________________ Claim No: _________________

Date: ________________________ Member's Signature: ________________

(PLEASE RETURN WITHIN 10 DAYS)

Figure H-1 Accident Questionnaire (cont.)
Duplication of Coverage

Notice and Allowance of Lien

I, (member name) acknowledge my obligation under the PacifiCare’s combined Evidence of Coverage disclosure form to reimburse PacifiCare ("PacifiCare") for the reasonable value of all benefits provided by PacifiCare as a result of the injuries I sustained on or about (date of accident) in the event that a monetary recovery is made as a result of the injuries.

To facilitate PacifiCare in the exercise of this right, I hereby authorize and direct defendants, insurance companies, and my attorney, (attorney name) (if applicable) to pay PacifiCare from the proceeds of any settlement, judgment or award the reasonable value of such additional benefits.

I understand that the reasonable value of the benefits provided by PacifiCare to me as a result of the injuries is $ (lien amount). Should PacifiCare provide additional benefits to me because of the injuries, I understand and agree that PacifiCare shall be reimbursed for the reasonable value of such additional benefits.

I also agree to compromise or settle any portion of any claim for damages and/or medical expenses brought as a result of the injuries without providing for full reimbursement to PacifiCare from the proceeds of such settlement. We will not compromise or settle any such claim without first obtaining the written consent of PacifiCare right to reimbursement.

Date: ___________________________ (member name)

I, (attorney name), attorney of record for (member name), agree to comply with the foregoing by withholding from the proceeds of any settlement, judgment or award the sum of $ (lien amount), less attorney’s fees and costs to be shared on a pro rata basis by my client, PacifiCare and any other lien claimants, to satisfy PacifiCare lien rights as set forth herein.

Date: ___________________________ (attorney name)

Figure H-2 Notice and Allowance of Lien
Duplicate of Coverage

(Sample Letter - Medical Group/IPA Lien Form)

Notice of Reimbursement Rights

I, (Member name), understand that I have an obligation under the PacifiCare combined Evidence of Coverage disclosure form, to reimburse PacifiCare for the reasonable value of all medical services provided to me by PacifiCare, in relation to my accident on (date) of accident, in the event that a recovery is made from a third party as a result of that accident.

I understand that PacifiCare has arranged with (Hospital) to provide me with medical services. The (Hospital) has/have provided medical services to me relating to this accident. Pursuant to Secure Horizons agreement with (Hospital), (Hospital) has the right to be reimbursed for the services provided to me by (Hospital) relating to this accident.

To facilitate the exercise of this right, I hereby authorize and direct defendants, insurance companies and attorney, (name of attorney), if applicable, to pay (Hospital) from the proceeds of any settlement or judgment made arising out of my (date) of accident for the reasonable value of medical benefits provided to me as a result of that accident.

Member Name: ____________________________  (Please Print)  Parent, or Guardian: ____________________________  (Please Print)

Member’s Signature: ____________________________  Signature: ____________________________

Date: ____________________________  Relationship to Member: ____________________________

Date: ____________________________

Figure H-3 Notice of Reimbursement Rights
Duplication of Coverage

(Sample letter - Medical Group/IPA Lien Form) Page Two

I, (attorney name), attorney for (name of member) agree to comply with the foregoing by remitting from the proceeds of any settlement, judgment or award, the reasonable value of the medical benefits provided by (Hospital) to my client as a result of his/her (date) accident less attorney’s fees and costs to be deducted from the settlement, judgment or award on a pro rata basis to satisfy (Hospital’s) lien rights as set forth herein.

_________________
Date

________________________________ ______________________________
Attorney’s Name (Please Print) Attorney’s Signature

Attorney’s Address: __________________________________________

__________________________________________
Telephone Number: (   ) ________________________  FAX: (   ) ___________________

cc: Secure Horizons
   Claims Cost Containment Unit

Figure H-3 Notice of Reimbursement Rights (cont.)
Section I: Service Denials

Denials/Notice of Coverage

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Section I: Service Denials

Claims Denials

Denials/Notice of Coverage

Service Denials

When a member requests a specific service, treatment plan or physician referral, the treating physician is required to review the request for medical necessity. If there is not sufficient medical indication for requested treatment, service or referral, the physician should offer an alternative treatment plan to the member.

A denial letter must be issued to the member for any service denials. All medical necessity denials are made by a physician.

Claims Denials

When a PacifiCare member receives services out-of-network and submits a claim for services paid by the member to PacifiCare or the delegated Network, the claim will be assessed for the following:

- Review the claim against emergent/urgent/ESRD criteria
- Review the chart for a verbal or written referral by the provider
- Review the appropriateness of the service(s)
- Determine if the service(s) would have been authorized if the member had gone through the proper channels
- Identify whether the provider of service is contracted
- Identify if this was a direct accessed service
- Identify if a claim for medical necessity or medical appropriateness must follow the UM process

In the event of a denial, PacifiCare or the delegated Network must send a letter of denial in accordance with NCQA, Federal, and State regulatory standards for retrospective review.
Medicare Member Continued Acute Stay Denial

Denials/Notice of Coverage

The continued acute stay denial applies to all inpatient admissions to an acute hospital, rehabilitation hospital, psychiatric hospital, subacute, SNF or TCU. The hospital must complete and distribute the standard notice “Important Message From Medicare” (HCFA-R-193) to all Medicare members at or about the time of the member’s hospitalization. The purpose of the Message is to inform all Medicare beneficiaries of what rights they have as a patient in an acute hospital and how to exercise those rights. CMS is requiring that hospitals distribute this notice to beneficiaries at or about the time of the beneficiary’s admission. Upon establishment of the member’s discharge date the hospital will again provide the member or member’s authorized representative with the notice. The member or the member’s representative will be asked by the hospital to sign the message prior to discharge to acknowledged receipt of the message. The hospital will retain the original copy and the member or his/her representative will be given a copy. The original form will be kept with the patient’s medical chart. Once the member or member’s representative has signed the document, the original copy must be kept in the medical record and a copy must be forwarded to Secure Horizons.

If the member or member’s authorized representative refuses to sign the acknowledgement, the hospital should immediately write (on the signature line) that the member or member’s authorized representative refused to sign and prepare a report for the files (i.e., medical records). Forward a copy of this report to PacifiCare. The date of the refusal is then considered the date of receipt. The notice provides information regarding the member's right to appeal to a Peer Review Organization (PRO) should the member disagree with the planned discharge date.

The statement must explain:

- The member’s rights to benefits for inpatient hospital services and for post-hospital services under Medicare
- The circumstances under which the member will and will not be liable for charges for continued stay in the hospital
Section I:

Denials/Notice of Coverage

Medicare Member Continued Acute Stay Denial (cont.)

- The member’s rights to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate the appeal
- The member’s liability for services in the denial of benefits is upheld on appeal
- Additional information as needed

The denial notice provides information regarding the member’s right to appeal to a Peer Review Organization (PRO) should the member disagree with the planned discharge date.

The PRO comprises physicians who are authorized by Medicare to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients including those enrolled in Secure Horizons.

- PacifiCare, the delegated Network, or Hospital is responsible for the following:
  - Advise the member at least 48 hours in advance of the planned discharge date
  - Verify that a notices has been issued to the patient
  - Secure the member’s signature acknowledging receipt of the notice of submit the “Refusal to Sign” notice to files
  - Copies of the signed notice (or “Refusal to Sign”) should be kept in the medical records of the facility

If the member feels they are being asked to leave the hospital too soon, they have a right to request a review by the PRO. They cannot be made to pay for their hospital care until the PRO makes its decision if they request review by noon of the first workday after they receive the notice. The PRO review should be completed within three days.

Note: If the member files an appeal and the PRO disagrees with the discharge date, a second notice must be issued to the member. HCFA views lack of documentation as an indication that the member never received the proper notification.
Credentialing Program

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Credentialing Program

Purpose

PacifiCare maintains standards, policies and procedures for credentialing and re-credentialing Participating Providers, hospitals and other health care professionals and facilities that provide covered services to members under the Managed Care Plans. The Credentialing Program is maintained in accordance with the requirements of State and Federal Law and the standards of Accrediting Organizations.

Objectives

PacifiCare performs pre-contractual quality assessments, at least every three years, and ongoing assessments to confirm that contracted organizational providers are approved by a recognized accrediting body and in good standing with state and regulatory authorities. If a recognized organization body has not approved the organization, PacifiCare will review the organizational provider according to established standards.

Accrediting Agencies

PacifiCare recognizes the following accrediting agencies:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- American Osteopathic Association Healthcare Facilities Accreditation Program (AOA-HFAP)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Certified Ambulatory Rehabilitation Facility (CARF)
- Counsel on Accreditation Community Health Accreditation Program (CHAPS)
- National Committee on Quality Assurance (NCQA)
- Medicare Certification and State Licensure

Organizational Providers

Organizational Providers include the following:

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities
- Free-Standing Surgical Centers
- Urgent Care Centers
### Credentials File

A confidential credentials file is maintained for each organizational provider.

All credentialing review elements are reviewed by the Credentialing Committee prior to issuing credentialing status to organizational providers to provide health care services to PacifiCare members.

### Hospital Licensing/Certification Requirements

The hospital will maintain the following:

- All licenses, certificates and/or approvals required under state and federal law for the performance of hospital services
- Medicare Certification
- Accreditation by a recognized accrediting agency such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The hospital is required to:

- Ensure that each hospital employee maintains in good standing at all times the necessary licenses or certifications required by state and federal law
- Provide to PacifiCare, upon request a complete list of its hospital providers
- Immediately restrict, suspend or prohibit hospital provider(s) from providing covered services to PacifiCare members when warranted

### Changes in Capacity

Should the hospital experience any change in its capacity to provide service, the hospital will provide PacifiCare with the following:

- 90 calendar days prior, written notice of the termination of any of its hospital providers
- 90 calendar days prior, written notice of any significant changes in capacity of hospital or its hospital providers to provide hospital services to members
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## PPO/POS

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PPO/POS

Product Overview

**Preferred Provider Organization (PPO):**

PPO is an organization which contracts with established providers of medical care. Providers are physicians, hospitals, outpatient surgery centers, laboratories, diagnostic centers, etc. Providers under such contracts are referred to as Participating Providers. Members covered under the PPO Plan are encouraged to use these Participating Providers for their health care needs. In return, the member receives significantly greater savings, in terms of cost. In addition, members are allowed to access Non-Participating Providers on an indemnity basis, with increased out-of-pocket expenses.

**Point of Service (POS) (HMO/PPO/POS or HMO/POS):**

PacifiCare Point of Service (POS) is built around flexibility. Whenever the need for medical care arises, members can choose whether they want to receive care directed by their Primary Care Physician (PCP) or Primary Medical Group, self-refer to a Participating Provider, or self-refer to any licensed Non-Participating Provider (all self-referrals are considered out-of-network). POS plans offer several benefit level options. A member’s out-of-pocket expenses will vary depending on which benefit level he or she selects at the time of service.

In-Network refers to health care services that are provided, arranged or directed by a member’s PCP or Primary Medical Group.

Out-of-Network refers to health care services initiated directly by the member without PCP or Medical Group prior authorizations.
Prior Authorization

PacifiCare shall be notified prior to all hospital/facility admissions and selected outpatient services. Participating providers are encouraged to assist members in obtaining prior authorization for services.

Prior authorization of services can be obtained by calling:

1-800-444-8152

The following information will be requested at the time of request:

- Covered Person’s name
- Covered Person’s ID number
- Covered Person’s primary diagnosis with appropriate ICD-9
- Procedure with CPT Code
- Estimated date of admission or service date
- Clinical information to substantiate medical necessity and appropriateness

Prior Authorization Requirements

Prior authorization is required for but not limited to the following services other than for emergency services (See Section C Emergency/Urgent Services Procedures):

- Inpatient Services
- Outpatient Services
- Transplant Services
- Home Health Services

Elective Admissions

Covered Persons should obtain prior authorization at least three (3) days prior to the date of services for all non-emergency (planned or elective) inpatient admissions and selected outpatient services.

Emergency Admissions

Notification of emergency inpatient admissions must be made to PacifiCare within two (2) business days, or as soon as reasonably possible.
### Catastrophic Case Management

Once a Catastrophic Case is identified, Case Management Specialists work with the member’s family and medical professional to develop an effective long-term treatment plan tailored to the member’s needs. This plan will include a medical evaluation, an outline of specific treatment goals and a concise plan of action around which the member, his/her family, employers, physician and other healthcare providers can focus their efforts.

Once the treatment plan is implemented, PacifiCare will continue to monitor the case and provide the member and his/her family with an ongoing source of information about additional treatment alternatives.

### Concurrent Review

PacifiCare performs comprehensive chart analysis on a concurrent basis. PacifiCare will validate admissions, determine the appropriate level of care and recommends a length of stay. In addition any quality of care, medical necessity and risk management issues will be monitored.

### Discharge Planning

PacifiCare will work closely with the attending physician and the hospital’s Discharge Planner to assure that member’s needs are met. This includes providing service information and confirming arrangements for the timely and appropriate discharge of the member.

### Retrospective Review

Retrospective review occurs when PacifiCare is notified of an admission after a member has been discharged. The case will be assessed for medical necessity and appropriateness of service. If prior authorization was required, benefits may be reduced. Services determined not to be medically necessary will not be covered.
Claims Submission

Claims must be submitted to PacifiCare using the industry standard billing forms. (Refer to Section G for Claims Submission Requirements.)

Inaccurate provider information may affect or delay claim payment.

Refer to the member’s ID card for appropriate claims submission location.

Assignment of Benefits

Assignment of benefits is necessary to ensure that payment is directed to the appropriate hospital or surgery center. As a contracted provider, the hospital is obligated to obtain a valid Assignment of Benefits and a Release of Records signature. All claims submitted must include a signature assigning benefits, or indicate “Assignment on File” otherwise PacifiCare is obligated to remit payment directly to the insured.

Dual Coverage and Coordination of Benefits

If the insurance carrier/payor has secondary responsibility, bill the primary insurance carrier/payor first with an assignment of benefits. When payment is received from the primary carrier, submit the claim along with the primary carrier’s Explanation of Benefits to the claims address on the Covered Person’s ID card.
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Medical Supplement

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Medical Supplement

Medical Supplement

A Medical Supplemental benefit is an Indemnity plan that provides secondary coverage to those members enrolled in traditional Medicare fee-for-service programs. This Indemnity plan is underwritten by PacifiCare Life Insurance Company and is offered under limited circumstances as an employer sponsored group retiree plan.

Medicare remains the primary coverage for member’s insured under the Indemnity plan. These members still receive all Medicare benefits and services because they remain in the traditional Medicare program. The Indemnity plan is designed to pay various co-insurance and deductible amounts not covered by Medicare. The level of coverage varies with each plan design.

The Indemnity Plan is separate from PacifiCare’s current HMO, PPO, POS, and Secure Horizons Medicare+Choice plans.

Networks

As an Indemnity plan, there are no provider networks associated with the Supplemental product for Medicare covered services. Members enrolled in this plan may seek care from any provider that accepts Medicare, including physicians and hospitals that are part of the PacifiCare contracted provider network.

Prescription drug benefits are provided through the Prescription Solutions National Pharmacy Network and utilize the PacifiCare drug formulary.

Eligibility/Enrollment

To participate in the Medical Supplemental program, a member must be enrolled in both Medicare Parts A and B and must be retired.

To help provide distinction from the other plans offered by PacifiCare, a product-specific identification card is given to members. This membership card should be provided along with the Medicare card at the time of service.
### Eligibility/Enrollment (cont.)

**Checking Eligibility**
To verify eligibility for the member contact the PacifiCare Administrative Services office at:

1-800-913-9133

**Note:** Eligibility can not be verified through the VRU/IVR or through On-Line Eligibility services.

**Claims**
Medicare is the primary payor for services rendered to retirees insured by Medical Supplemental.

In most cases providers WILL NOT be required to submit any additional claims paperwork directly to PacifiCare for Medicare covered services.

**Prior Authorization**
PacifiCare does not require prior authorization for any covered benefits for Medical Supplement. All benefits covered by traditional Medicare must meet all requirements and guidelines established by the Centers for Medicare and Medicaid Services (CMS).