

**PacifiCare®**

# ***SignatureOptions (PPO)***

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***Provider Policy & Procedure Manual***

**2006 Manual  
Prepared by:**

PacifiCare  
Provider Operations

**PACIFICARE**

**PPO PROVIDER**

**POLICY & PROCEDURE**

**MANUAL**

**DISCLAIMER**

As an attachment to the PacifiCare PPO Provider Services Agreement, this Manual is intended for use by PacifiCare participating providers and practitioners only. This Manual is to be used only by employees or other personnel acting on behalf of PacifiCare or its participating providers and practitioners who are responsible for administering or authorizing benefits as part of their employment or contract responsibilities. The information contained within this Manual is strictly confidential and proprietary to PacifiCare. The information is not to be copied in whole or part; the information is not to be distributed without the express written consent of PacifiCare.

*In the state of Nevada, PPO providers contracted with Nevada Preferred Professionals (NPP) that see PacifiCare PPO members should contact NPP to obtain a copy of a Policy and Procedure Manual.*

**Introduction**

Welcome to PacifiCare's Preferred Provider Organization (PPO). PacifiCare Life and Health Insurance Company (PLHIC) or PacifiCare Life Assurance Company (PLAC), cumulatively referred to herein as "PacifiCare," underwrite PacifiCare's SignatureOptions (formerly PPO) plans.

This SignatureOptions Participating Provider Policy & Procedure Manual is designed to provide important information about how PacifiCare's SignatureOptions plans function, explain PacifiCare's SignatureOptions policies and procedures, and answer some frequently asked questions.

PacifiCare contracts with established medical care providers, including physicians, hospitals, outpatient surgery centers, laboratories and diagnostic centers, to create a health care network for its insureds and their eligible dependants, cumulatively referred to herein as "covered persons." Contracted providers are called Participating Providers.

Covered persons enrolled in the PacifiCare SignatureOptions plans may obtain covered services from any qualified medical care providers. Covered persons may receive greater cost savings by obtaining covered services from Participating Providers.

Participating Providers must ensure that covered services are provided to PacifiCare SignatureOptions covered persons equally, fairly and in accordance with State and Federal laws.

Participating Providers must provide covered services to covered persons, including those with ethnic backgrounds, physical or mental disabilities and limited English proficiency, in a culturally competent manner and at the Participating Provider's expense.

Participating Providers must provide disabled covered persons with the assistance necessary to effectively communicate with the Participating Providers and their staffs, as required by the Americans with Disabilities Act.

**Introduction  
Continued**

Participating Providers must ensure that covered persons are not unlawfully discriminated against on the basis of race, color, creed, national origin, ancestry, religion, sex, marital status, age, physical or mental handicap, or in any other manner prohibited by State or Federal laws.

PacifiCare and its Participating Providers must adhere to the Health Insurance Portability and Accountability Act (HIPAA) regulatory requirements relating to the electronic exchange of health information.

PacifiCare's SignatureOptions plans are created to meet all State and Federal laws. If any PacifiCare SignatureOptions plan term conflicts with any State or Federal Law, the plan shall be interpreted to meet the minimum State or Federal law requirements.

This Manual is an integral part of the PacifiCare PPO Provider Agreement. If there are questions regarding this Manual, feel free to contact PacifiCare's National Service Center at (866) 863-9776 and ask for the PPO Provider Relations Department or send a fax at (714) 226-8513, Attention: PPO Management.

**PacifiCare History**

From a philosophical perspective, PacifiCare Health Systems (PHS) defines itself as "an organization dedicated to making people's lives better."

In practice, this philosophy is reflected in the company's emphasis on providing Members with quality health care and responsive customer service. It also is reflected in the mutually beneficial relationships that PacifiCare establishes with its network of physicians and hospitals. It is PacifiCare's belief that they, as well as Members, must "win" in order for the organization as a whole to succeed.

PacifiCare Health Systems also believes that success should be shared, and is truly committed to "giving back" to the communities it serves.

**PacifiCare History  
Continued**

Not only does the company support a broad range of philanthropic organizations on an ongoing basis, but also in 1991, it formed a non-profit foundation of its own. Since that time, the PacifiCare Foundation has made contributions totaling more than seven million dollars to the communities PHS serves.

PacifiCare began operations in 1978 as a non-profit health maintenance organization under the sponsorship of the Lutheran Hospital Society of Southern California (now UniHealth America). In 1984, PacifiCare converted from non-profit status to for-profit status. In 1985, PHS was created as a holding company and transferred to a publicly held company.

In 1985, PacifiCare was awarded one of the first Medicare risk contracts, now the largest in the nation. By 1989, PacifiCare Health Systems had established managed care organizations in five states, and membership system-wide surpassed the 500,000-member mark. This growth trend continued, and in fiscal 1992, the company set new records in revenue, earnings and membership.

Today, PacifiCare Health Systems is one of the nation's largest health and consumer services companies. Primary operations include health insurance products for employer groups and Medicare beneficiaries in eight western states and Guam. Other specialty products and operations include behavioral health services, life and health insurance, dental and vision services, and pharmacy benefit management. At PacifiCare, we believe that, "Caring is good, doing something is better."

**Product Naming**

As a leading Consumer Health Organization serving more than 3 million Members, PacifiCare created an easy-to-use and recognizable naming system for consumers. Our goal is to alleviate consumer confusion over health care products and begin to change the negative perception of managed care in the marketplace.

Refer to the below chart for current PacifiCare product names:

| Industry Name              | PacifiCare Name                                   |
|----------------------------|---|
| HMO                        | PacifiCare SignatureValue <sup>SM</sup>           |
| Value Network (CA only)    | PacifiCare SignatureValue <sup>SM</sup> Advantage |
| Skinny EPO                 | PacifiCare SignatureValue <sup>SM</sup> Elect     |
| Open Access HMO/EPO        | PacifiCare SignatureValue <sup>SM</sup> Direct    |
| POS                        | PacifiCare SignaturePOS <sup>SM</sup>             |
| PPO                        | PacifiCare SignatureOptions <sup>SM</sup>         |
| National Accounts EPO      | PacifiCare SignatureValue <sup>SM</sup> Access    |
| SDHP                       | PacifiCare SignatureFreedom <sup>SM</sup>         |
| SDHP + EPO Network         | PacifiCare SignatureFreedom <sup>SM</sup> Elect   |
| Indemnity                  | PacifiCare SignatureIndependence <sup>SM</sup>    |
| Employeee                  | PacifiCare SignatureExpress <sup>SM</sup>         |
| Discount Dental and Vision | PacifiCare SignatureSavings <sup>SM</sup>         |

*Disclaimer*

*Introduction*

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*Section B* *Medical/Utilization Management Program*

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*Section F* *Provider Notification*

*Section G* *Appeals & Grievances*

*Section H* *Billing & Compensation*

*Section I* *Claims Reconsideration and Provider Disputes*

*Section J* *Duplication of Coverage*

*Section K* *Pharmacy Control Program*

*Section L* *Electronic Data Interchange (EDI)*

*Section M* *Clinical Denials*

*Section N* *Additional Products*

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**Enrollment & Eligibility**

**Revision Date: 06/2005**

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**Eligibility,  
Enrollment &  
Effective Date**

In order to receive PacifiCare PPO plan benefits, a person must be eligible for plan coverage, enrolled in the plan, and seek services on or after the person's plan effective date. Any person who fails to satisfy these PPO plan requirements is not a covered person under the plan and has no right to plan benefits.

**Note:** Covered persons must present an identification card prior to receiving services; however, presentation of an identification card does not guarantee a person's eligibility. The card is for identification purposes only.

**A Participating Provider needs to verify a person's current PPO plan enrollment and benefits each time that person seeks services for the following reasons:**

- A person may not be or may no longer be eligible for the PPO plan coverage;
- A person may not be or may no longer be enrolled in the PPO plan;
- A person may not be beyond his/her PPO plan coverage effective date;
- An employer group may have terminated the PPO plan
- The PPO plan benefits may have changed;
- The PPO plan benefits may have been supplemented;
- The PPO plan copayment, coinsurance and/or deductible amounts can be verified; and
- Fraudulent use of the PPO plan can be avoided.

**Mechanisms for  
Checking Eligibility  
& Benefits**

PacifiCare PPO enrollment and benefits can be verified through the following:

- PacifiCare Provider Web Site
- Interactive Voice Response (IVR)
- Regional Customer Service Center

**PacifiCare Provider  
Web Site**

PacifiCare's provider web site provides easy access to eligibility information 24 hours a day, 7 days a week. You can batch access and place up to ten (10) requests at a time and receive a printout of the information. Visit the PacifiCare provider web site at [www.pacificare.com](http://www.pacificare.com).

Access is easy, simply follow these directions:

- Click on "Provider Area"
- Select applicable state
- Enter your PacifiCare identification number and password
- Select "Check Eligibility"

Your PacifiCare Network Management Operations Associate can provide your PacifiCare provider identification number and assist with any questions or problems you encounter. Upon initial access to this service, you will need to register to obtain a password.

The eligibility function provides a confirmation number and covered person's eligibility information.

Further detailed benefit information, as outlined below, is available by clicking on the covered person's identification number in the primary eligibility screen:

**Covered Person's Information**

- Identification number
- Date of birth
- Gender
- Insured indicator – subscriber or dependent

**PacifiCare Provider  
Web Site Continued**

**Employer Group Information**

- Coverage dates
- Employer group name
- Employer group identification number

**Benefit Information**

- Office visit copayment
- Specialist office visit copayment
- Hospital copayment
- Emergency room copayment
- Emergency room copayment waiver
- Ambulance copayment

**Interactive Voice  
Response (IVR)**

PacifiCare's Interactive Voice Response (IVR) is available 24 hours a day, 7 days a week, at:

**(866) 863-9776**

The IVR provides eligibility and some benefit information. The following information is available through the IVR:

- Insured identification number;
- Eligibility verification number, for your records;
- Hospital and office visit copayment;
- Emergency room copayment and waiver information;
- Other deductible, copayment and benefit information.

**Customer Service**

For faster service, Providers are encouraged to use the PacifiCare web site or IVR. If the Provider requires more detailed benefit information than is provided through the IVR, the Provider may opt to speak with a PacifiCare Customer Service representative. Contact the Regional Customer Service Center at:

(866) 863-9776

CO ASO (800) 255-1180 / TDD (800) 659-2656

CO ASO CoverColorado (877) 461-3811 /  
TDD (800) 659-2656

**Copayments,  
Coinsurance &  
Deductibles**

A **copayment** is that portion of a covered expense that is the covered person's responsibility as indicated in the covered person's Schedule of Benefits. Copayments do not always apply towards the deductible and do not accrue toward the coinsurance maximum. Copayments are still required after the coinsurance maximum is reached.

**Coinsurance** is "a cost-sharing requirement under a health insurance policy requiring the insured to assume a portion or percentage of the costs of covered services. Usually the insured first pays a required deductible and then the coinsurance applies to any remaining medical expenses."

In addition, coinsurance is the portion of a covered expense that is not payable as a benefit because the percentage payable is less than one hundred percent (100%). Coinsurance does not include:

- Deductibles and copayments;
- Any amounts payable by the covered person because pre-authorization was not obtained;
- Any amounts payable by the covered person which are not considered a covered expense.

A **deductible** is the portion of a covered expense that a covered person must pay before the PacifiCare PPO plan benefits become payable.

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**Section A: Collection of Copayments, Coinsurance & Deductibles**

**Enrollment & Eligibility**

**Revision Date: 06/2005**

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**Collection of  
Copayments,  
Coinsurance &  
Deductibles**

The Participating Provider should collect the copayment indicated on the Schedule of Benefits at the time the covered service is rendered. The covered person may be billed for coinsurances, deductibles and any other amounts due to the Participating Provider after PacifiCare makes its payment.

# Sample ID Card

|  |  |
|--|--|
| <b>PacifiCare</b><br><i>Signature Options™</i>   |  |
| <b>ALIAS JONES</b><br>999999999-01<br>DOB 02/12/1956<br>SAN BERNARDINO MEDIC<br>GROUP# 90156633<br>EFF. DATE 06/01/2004<br>PPO | <b>COPAY AMOUNTS</b><br>OV \$15<br>RX \$100/\$250/\$50NF                     |
|  | ALBEM: 810494<br>ALPCAR: 9999<br>Subscriber Group: PPOPLM<br>Issue# 02-00040 |

|   |  |
|---|--|
| <b>www.pacificare.com</b>   |  |
| <b>EMERGENCY SERVICES:</b> Call 911 or go to the nearest emergency room. Notify Company within 2 business days of admission to a hospital.  |  |
| <b>NON-EMERGENCY:</b> To avoid additional expense, obtain preauthorization 3 days before receiving specified services by calling 1-866-856-9776.  |  |
| <b>PROVIDER SEARCH:</b> At home or when traveling out of area, please call Customer Service or visit <a href="http://www.pacificare.com">www.pacificare.com</a> . Always present ID Card to Provider.   |  |
| <b>Customer Service Department: 1-866-316-9776 (For TDD devices: 1-866-856-2018)</b><br>Monday - Friday, 9:00 a.m. - 9:00 p.m.      Send medical claims to: P.O. Box 6099, Cypress, CA 90630<br>Send other inquiries to: P.O. Box 1098, Cypress, CA 90630   |  |
| <b>NOTICE TO PROVIDERS</b><br>Portation of this card does not guarantee eligibility.<br>To confirm eligibility, call: 1-866-856-9776<br>Pharmacy Help Desk: 1-800-388-7871<br>Send Rx Claims to: P.O. Box 6057, Half Moon Bay, CA 94040<br>Prescription drug benefits are administered by Prescription Solutions®<br>Underwritten by PacifiCare Life and Health Insurance Company |  |
|   |  |

# Sample ID Card (NV only)

**PacificCare**  
Aetna Health Company

**NFP**

JEAN C. PUBLIC  
123456789  
DOB 8/2/78  
ADVENTURE 16  
GROUP# XXXXXXXX  
EFF. DATE 7/1/03  
PPO

COPAY AMOUNTS  
OV \$0x  
RX \$0x/\$0x/\$0x

Plan#: 610494  
Plan#: 2023  
Submitted Group: xxx  
Issuer: 00540

**Medical/Utilization Management Program**

**Revised: 06/2005**

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**Medical/Utilization Management Program****Revised: 06/2005**

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**Purpose**

The PacifiCare Medical Management/Utilization Management (MM/UM) Program is designed to ensure consistent, quality care and cost-effective, medically necessary utilization of services for the covered persons that are delivered in a manner compliant with all regulatory requirements. The MM/UM Program applies to covered services delivered in both inpatient and outpatient settings.

PacifiCare maintains a proactive, comprehensive Medical Management/Utilization Management (MM/UM) Program to conduct resource management and quality management through:

- Pre-Authorization Review (prior-authorization);
- Concurrent Review (telephonic and onsite review);
- Discharge Planning;
- Retrospective Review/Medical Claims Review;
- Case Management;
- Medical cost management utilizing data and reports;
- Monitoring of quality outcomes;
- Monitoring and management of overall clinical resource utilization;
- PacifiCare assumption of medical/utilization management processes as indicated.

The program ensures that Participating Providers have adequate systems and resources in place for the optimal management and delivery of health services to covered persons. It supports the identification of covered persons with complex and serious conditions to ensure that appropriate care and services are rendered.

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**Medical/Utilization Management Program****Revised: 06/2005**

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**Purpose  
Continued**

The Provider will participate, cooperate and comply with all aspects of PacifiCare's MM/UM Program with respect to health care services provided or arranged for by the Provider.

PacifiCare requires that covered services performed on behalf of its covered persons, be provided in a culturally sensitive manner, including 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/UM Program includes:

- Responding to requests from PacifiCare regarding MM/UM activities;
- Maintaining accurate, timely and consistently formatted medical records;
- Making available medical records pertaining to PacifiCare covered persons, as requested;
- Assisting PacifiCare's MM/UM staff in case management, concurrent review, discharge planning and retrospective claims review activities;
- Providing on-site access to PacifiCare covered persons and their families while in the facility;
- Providing on-site access to the covered person's medical records.

**Notification  
Requirements**

Providers are required to notify PacifiCare of all admissions, changes to inpatient status and discharge dates. Notification allows PacifiCare to verify eligibility, provide the Provider with a tracking number and facilitates the MM/UM clinical review and timely and accurate claims payment process, as outlined in this Manual.

**Please note:** Issuance of a tracking number does not constitute authorization for admission.

**Notification  
Requirements  
Continued**

Failure to comply with the notification requirements shall result in a reduction of the benefits payable by PacifiCare for covered services as shown in the Schedule of Benefits.

The Participating Provider shall not charge the covered person for services deemed not medically necessary, unless the covered person has agreed in advance, in writing, to pay for services. Pre-authorization does not guarantee eligibility or benefits at the time of service.

Some custom plans and payors may have additional pre-authorization requirements. Contact PacifiCare at (866) 316-9776 for specific pre-authorization requests for custom plans.

**Pre-Authorization  
Review Process**

Pre-authorization is a process that examines the medical necessity of a procedure or service and must be obtained by the covered person from PacifiCare prior to receiving such procedure or service from the Provider. The basic elements of pre-authorization review include:

- Eligibility verification;
- Benefit interpretation and medical necessity review; and
- Is conducted by clinical and non-clinical staff.

The covered person is required to comply with the notification requirements and obtain pre-authorization to avoid a reduction in benefits.

Pre-authorization requests are reviewed to verify eligibility and benefit coverage and determine that:

- The benefit(s) is a covered service available under the covered person's health insurance plan;
- The service is provided at the appropriate level of care;
- The service meets criteria for medical necessity (according to accepted, nationally recognized resources such as Milliman Care Guidelines, etc.).

**Pre-Authorization  
Review Process  
Continued**

Although the covered person is responsible for obtaining pre-authorization, PacifiCare encourages Providers to assist their patients in getting pre-authorization. Pre-authorization must be obtained from PacifiCare three (3) business days before the actual date of service.

The pre-authorization review process allows for the early identification and reporting of the following:

- Third party liability cases;
- Institutionalized covered person;
- Covered person with end stage renal disease;
- Covered person receiving hospice care;
- Quality of 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;
- Covered persons who may benefit from case management/disease management programs.

PacifiCare's pre-authorization list is subject to change. The Provider should always call PacifiCare at (866) 863-9776 to determine if pre-authorization is needed for a specific service.

PacifiCare will review submitted medical information to determine the medical necessity and appropriateness of the service. Review determinations are made in accordance with State-mandated timeliness standards. Services deemed not medically necessary are ineligible for coverage.

In most instances, medical records are required for review. The covered person must authorize the release of such records to PacifiCare in order for the MM/UM staff to determine medical necessity.

**Emergency  
Notification  
Requirements**

Notification of emergency inpatient admissions must be made to PacifiCare within two (2) business days of admission to a hospital or facility by calling PacifiCare at (866) 863-9776.

The following information will be requested by PacifiCare's UM department:

- Covered person's name
- Covered person's identification number
- Primary diagnosis with appropriate ICD-9CM code(s)
- Procedure(s) with CPT code(s)
- Estimated date of admission or service date
- Facility name
- Clinical information to substantiate medical necessity and appropriateness
- Information on any co- or assistant surgeons

**Emergency  
Condition  
Definition**

Emergency services are covered services required by a covered person 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 insured in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part;
4. Active labor, meaning labor at a time that either of the following would occur:
  - Inadequate time to effect safe transfer to another hospital prior to delivery; or
  - Transfer may pose a threat to health and safety of patient or unborn child.

**Admissions**

The Hospital/Provider should notify PacifiCare telephonically prior to all elective inpatient admissions (this includes skilled nursing facilities, acute rehabilitation, long-term acute and surgical admissions) by calling (866) 863-9776. This notification line is open 24 hours a day, 7 days a week, 365 days a year. For emergency admissions, notification shall occur once the patient is stabilized in the emergency department and no more than two (2) business days after the admission

**Concurrent Review**

PacifiCare defines concurrent review as an assessment that determines medical necessity, appropriateness and quality of care services as they are being rendered, in the acute inpatient and transitional care settings.

Concurrent review is performed telephonically, as well as on-site, at designated facilities by clinical staff and includes the following:

- Review of intensity of service and severity of illness;
- Initiation and coordination of a covered person's efficient discharge from an inpatient facility;
- Research/coordination alternatives to inpatient care;
- Appropriateness of level of care;
- Assessment of quality of care.

Procedures are established for onsite concurrent review at facilities, which include guidelines for identification of plan staff at the facility, processes for scheduling onsite reviews in advance, and ensuring that plan staff follows facility rules.

Criteria used to evaluate length of stay (LOS) and level of care (LOC) may include, but are not limited to:

- Milliman Care Guidelines
- HCIA length of stay designations
- Medicare Guidelines
- Other industry standards

The Provider 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 to ensure:

- Each day is medically necessary;
- Services are provided at the appropriate level of care; and
- All discharge arrangements have been made.

If the clinical reviewer determines that the covered person may be treated at a lower level of care or in an alternative treatment setting, the case will be discussed with PacifiCare's Medical Director.

**Concurrent Review  
Continued**

If applicable, PacifiCare's Medical Director or designee will discuss the insured's clinical status and treatment plan with the Provider.

Admissions or continued hospitalization that do not meet medical necessity, or any delays in discharge attributed to lack of, or delay in, providing covered services shall result in non-payment to the Provider, and the covered person will not be billed for any such services.

The Hospital shall 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;
- Allowing on-site access to all units;
- Permitting bedside access to speak to covered persons and family;
- Allowing PacifiCare staff to participate in individual case conferences;
- Facilitating discussion and case review with the Provider and the PacifiCare Medical Director, as requested;
- Providing appropriate services in a timely manner.

PacifiCare or its agents are responsible for the authorization for medical services provided to the covered person. If a Provider has obtained concurrent or prior authorization for a covered service provided to the covered person, PacifiCare or its agents will not retrospectively deny payment for such prior authorized covered service, **unless** the Provider'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 or does not match the service that was specifically authorized.

**Concurrent Review  
Continued**

PacifiCare may review specific claims based on pre-established retrospective claim review criteria to ensure acceptable billing practices are applied.

PacifiCare or its agents shall conduct review throughout a covered person's course of treatment, and multiple authorizations may be required throughout such course of treatment. The Provider acknowledges that initial and subsequent authorizations may be limited to specific services or time periods, requiring the Provider to ensure that subsequent authorizations are obtained.

**Retrospective  
Review**

Retrospective review is an assessment of the medical necessity and appropriateness of services after they have been rendered, utilizing the same review criteria as with prior authorizations.

Benefits may be reduced if pre-authorization was required and PacifiCare was not notified until after discharge. Failure to comply with PacifiCare's concurrent review process may result in a retrospective review and/or non-payment of hospital and/or provider services to the Provider. Retrospective review involves examination of the medical documentation and billing after service has been provided. No reimbursement will be made for services that are considered not to be medically necessary or excluded from the benefit plan.

When PacifiCare requests medical records from a Provider for the limited purpose of claims review for services rendered to a covered person, PacifiCare will reimburse the Provider for the reasonable cost of copying, which shall be five cents (\$0.05) per page, not to exceed five dollars (\$5.00) per record.

Along with the medical record copies, the Provider must submit an invoice to PacifiCare with satisfactory detail to substantiate the number of copies made per record. PacifiCare will reimburse the Provider from the invoice for all eligible copying expenses.

**Discharge Planning**

Discharge planning is the coordination of a covered person'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:

- Assessing a covered person's potential discharge requirements beginning the day following admission. This assessment includes documentation of the covered person's functional status and anticipated discharge disposition;
- Evaluating available support and assistance, financial needs, skilled services and/or DME requirements;
- Arranging multidisciplinary meetings, as appropriate, to include patient and family, if necessary;
- Involving social service in discharge plan, as appropriate;
- Coordinating discharge needs to include DME, home health (HH), skilled nursing facility (SNF), transportation and medications, seven (7) days a week;
- Obtaining authorizations for necessary post-discharge plan;
- Documenting and communicating the discharge plan;
- Making referrals to Case Management and Disease Management programs.

The attending physician is required to facilitate discharge planning by documenting the anticipated discharge disposition (home, SNF, other) and any services the covered person may require. PacifiCare's UM staff will work with the attending physician, hospital case managers and discharge planners in assessing the discharge planning needs of the covered person throughout the hospital stay. The attending physician shall document the covered person's condition relative to discharge and reassess daily.

PacifiCare's MM/UM staff and the hospital case manager will collaborate on frequent assessments to determine any changes in the covered person's condition, needs, support system or resource requirements which might require alterations in the discharge plan.

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 the final discharge planning, which will include an assessment of the covered person's knowledge and/or understanding of the post-hospital care.

**Case  
Management**

Medical case management seeks to facilitate and coordinate appropriate and cost-effective health care services for certain injuries or sicknesses. Medical case management strategies include timely identification of potential cases, referral to a qualified case manager, assessment of the patient's situation, development of a written treatment plan, on-going evaluation and documentation of the patient's progress, patient advocacy in the areas of cost containment and quality of care, and promotion of the patient's self-sufficiency in achieving maximum outcomes.

PacifiCare's Case Manager facilitates communication and coordination between all members of the health care team, involving the covered person and family in the decision-making process in order to minimize fragmentation of the health care delivery system. The PacifiCare Case Manager will be responsible for assessing the needs and educating the covered person, his or her family, if appropriate, and all of the 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 can be made.

**Case  
Management  
Identification**

Potential case management cases will be evaluated by PacifiCare's Case Management staff based on the following criteria:

- Specific diagnosis codes;
- A case that is expected to exceed \$50,000 in covered services.

Once a case is identified and accepted, the PacifiCare Case Manager will assist the covered person, his or her family, and medical professionals in timely coordination of quality health care services to meet the covered person's needs. The treatment plan includes a medical evaluation and an outline of specific treatment goals.

PacifiCare's Case Managers follow national standards developed by industry leaders, including the Case Management Society of America (CSMA), which is a dynamic model of screening, assessment, care planning, service allocation/referral, monitoring and reassessment.

Once the treatment plan is implemented, a PacifiCare Case Manager will continue to monitor the case and provide the covered person and his or her family with an ongoing source of information about additional treatment alternatives.

## DISEASE & CASE MANAGEMENT PROGRAMS

To make a referral, please complete the Program Referral Fax Form & fax it to 877/406-8212 (toll-free).

For questions regarding the programs or the referral process, please call 877/840-4085 (toll-free).

### **Congestive Heart Failure (CHF) Program/Alere® Medical Incorporated**

| Program Components:  | Eligible Population:  | Exclusions:  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Daily in home monitoring by a nurse via the DayLink® monitor (a precision electronic scale and communication device)</li> <li>• Physician/provider communication</li> <li>• Member/caregiver education to improve symptom management and to help prevent complications</li> </ul> | <ul style="list-style-type: none"> <li>• PacifiCare SignatureOptions (PPO) members</li> <li>• Members with CHF</li> </ul> | <ul style="list-style-type: none"> <li>• ESRD</li> <li>• Organ transplant</li> <li>• Under age 18</li> </ul> |

### **Chronic Obstructive Pulmonary Disease (COPD) Program/AirLogix, Inc.**

| Program Components:  | Eligible Population:   | Exclusions:  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Three-tiered intervention structure based on disease severity: educational materials, telephonic visits, and home visits</li> <li>• Physician/provider communication</li> <li>• Member/caregiver education to improve symptom management and to help prevent complications</li> </ul> | <ul style="list-style-type: none"> <li>• PacifiCare SignatureOptions (PPO) members</li> <li>• Members with COPD</li> </ul> | <ul style="list-style-type: none"> <li>• ESRD</li> </ul> |

### **Cancer Program/Quality Oncology, Inc.**

| Program Components:  | Eligible Population:   | Exclusions:   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Telephonic care management</li> <li>• Physician/provider communication</li> <li>• Member/caregiver education to improve symptom management and to help prevent complications</li> </ul> | <ul style="list-style-type: none"> <li>• PacifiCare SignatureOptions (PPO) members</li> <li>• Members in active treatment for cancer or after treatment</li> </ul> | <ul style="list-style-type: none"> <li>• ESRD</li> <li>• Carcinoma in situ</li> <li>• Basal and squamous cell skin cancers</li> <li>• Under age 18</li> </ul> |

### **End Stage Renal Disease (ESRD) Program/Renaissance<sup>SM</sup> Health Care, Inc.**

| Program Components:   | Eligible Population:   | Exclusions:   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Coordination of care by registered nurse (RN)</li> <li>• Physician/provider communication</li> <li>• Member/caregiver education to improve symptom management and to help prevent complications</li> </ul> | <ul style="list-style-type: none"> <li>• PacifiCare SignatureOptions (PPO) members</li> <li>• Members on chronic dialysis</li> </ul> | <ul style="list-style-type: none"> <li>• Medicare Primary</li> <li>• Transplant</li> <li>• Acute renal failure</li> <li>• Under age 18</li> </ul> |

### **Frail Member Program**

| Program Components:  | Eligible Population:   | Exclusions:  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Telephonic care management</li> <li>• Coordination of services</li> <li>• Physician/provider communication</li> </ul> | <ul style="list-style-type: none"> <li>• PacifiCare SignatureOptions (PPO) members</li> <li>• Members with 2+ ER visits and/or 2+ hospitalizations within 12 months with multiple medications</li> </ul> | <ul style="list-style-type: none"> <li>• None</li> </ul> |

## DISEASE & CASE MANAGEMENT PROGRAMS CONT.

### **Free & Clear<sup>®</sup>/StopSmoking<sup>SM</sup> Program**

| Program Components:  | Eligible Population:   | Exclusions:  |
|--|--|--|
| <ul style="list-style-type: none"> <li>Self-paced smoking cessation program including telephonic support and interactive Member materials</li> <li>Smoking cessation aids (nicotine patches or Zyban<sup>®</sup>) are available to participants</li> <li>\$20 enrollment fee (waived for members with a chronic disease or who have been recently hospitalized)</li> </ul> | <ul style="list-style-type: none"> <li>PacifiCare SignatureOptions (PPO) members</li> <li>Members who are tobacco users</li> </ul> | <ul style="list-style-type: none"> <li>Under age 18</li> </ul> |

### **Taking Charge of Depression<sup>®</sup> Program**

| Program Components:  | Eligible Population:   | Exclusions:  |
|--|--|--|
| <ul style="list-style-type: none"> <li>Telephonic support promoting Member self-care</li> <li>Educational materials supporting medication compliance and self-care mailed to the Member</li> <li>Provider communication</li> </ul> | <ul style="list-style-type: none"> <li>PacifiCare SignatureOptions (PPO) members</li> <li>Members diagnosed with a new episode of depression and prescribed an antidepressant</li> </ul> | <ul style="list-style-type: none"> <li>Under age 18</li> </ul> |

### **Taking Charge of Diabetes<sup>®</sup> Program**

| Program Components:  | Eligible Population:   | Exclusions:  |
|--|--|--|
| <ul style="list-style-type: none"> <li>Self-care and preventive care educational materials mailed to the Member two or more times per year</li> <li>Glucose meters free of charge</li> </ul> | <ul style="list-style-type: none"> <li>PacifiCare SignatureOptions (PPO) members</li> <li>Members with diabetes</li> </ul> | <ul style="list-style-type: none"> <li>Under age 18</li> </ul> |

### **Taking Charge of Your Heart Health<sup>®</sup> Program**

| Program Components:   | Eligible Population:   | Exclusions:  |
|---|--|--|
| <ul style="list-style-type: none"> <li>Self-care and preventive care educational materials mailed to the Member two or more times per year</li> </ul> | <ul style="list-style-type: none"> <li>PacifiCare SignatureOptions (PPO) members</li> <li>Members with CHF or CAD</li> </ul> | <ul style="list-style-type: none"> <li>Under age 18</li> </ul> |

### **Taking Charge of Asthma<sup>SM</sup> Program**

| Program Components:   | Eligible Population:   | Exclusions:   |
|---|--|---|
| <ul style="list-style-type: none"> <li>Age specific educational materials mailed to the Member two or more times per year (ages 5-11, 12-17, or 18+)</li> <li>Asthma assessment tool</li> </ul> | <ul style="list-style-type: none"> <li>PacifiCare SignatureOptions (PPO) members</li> <li>Members with asthma</li> </ul> | <ul style="list-style-type: none"> <li>Under age 5</li> </ul> |

**PROGRAM REFERRAL FAX FORM**

|                |  |                                      |
|----------------|--|--------------------------------------|
| Referral Date: | To:  | Toll Free Fax: <b>(877) 406-8212</b> |
|                | Dept: Population/Disease Management Project Team | Toll Free Phone: (877) 840-4085      |

|                         |                       |                     |
|-------------------------|-----------------------|---------------------|
| From (Referral Source): | Phone:<br>( ) ( ) ( ) | Fax:<br>( ) ( ) ( ) |
| Company & Department:   | Title:                | Email Address:      |

|  |                                  |  |
|--|----------------------------------|--|
| <b>Enrollee Name:</b> <b>First</b> <b>MI</b> <b>Last</b> | Enrollee ID:                     | Plan: (check one)<br><input type="checkbox"/> PPO (insured)              |
| Enrollee Phone:<br>( ) ( ) ( )                           | Enrollee DOB:                    | <input type="checkbox"/> ASO product (self-funded)                       |
| Enrollee Address:  |                                  | <input type="checkbox"/> Medicare PPO*                                   |
| Treating Physician Name:                                 | Physician Phone:<br>( ) ( ) ( )  | Gender:<br><input type="checkbox"/> Male <input type="checkbox"/> Female |
| Specialist Name:   | Specialist Phone:<br>( ) ( ) ( ) | Physician Fax:<br>( ) ( ) ( )  |
|  |                                  | Specialist Fax:<br>( ) ( ) ( )   |

*Please indicate program selection(s) by checking the appropriate box(es) and providing required information.  
Please transmit with a confidential fax cover sheet.*

**Disease Management Programs**

- Congestive Heart Failure \***  
*(must be able to stand unassisted)  
(excludes dialysis, pediatrics, and organ transplants)*  
Most recent admission date \_\_\_/\_\_\_/\_\_\_
- Chronic Obstructive Pulmonary Disease \***  
*(excludes enrollees on dialysis)*  
Most recent admission date \_\_\_/\_\_\_/\_\_\_
- Asthma Disease Management – ASO only**  
*(excludes enrollees on dialysis)*  
Most recent admission date \_\_\_/\_\_\_/\_\_\_
- End Stage Renal Disease**  
*(dialysis patients only)  
(excludes pediatrics, organ transplants, and Medicare Prime)*  
 hemodialysis     peritoneal dialysis  
  
Dialysis center \_\_\_\_\_  
Dialysis start date \_\_\_/\_\_\_/\_\_\_
- Cancer**  
*(excludes ESRD, pediatrics, carcinoma in situ, and basal or squamous cell skin cancer)*  
Cancer Dx confirmed?    Yes  No   
Patient aware of cancer Dx?    Yes  No   
ICD-9 code \_\_\_\_\_  
Stage \_\_\_\_\_  
Known metastatic sites \_\_\_\_\_  
Most recent admission date \_\_\_/\_\_\_/\_\_\_  
Planned discharge date \_\_\_/\_\_\_/\_\_\_

**Health Management Programs**

- Free & Clear® StopSmoking<sup>SM</sup> (age 18+)**  
(800) 292-2336 to self-enroll
- Taking Charge of Depression® (age 18+)**  
*(diagnosed with a new or recurring episode of depression and prescribed an anti-depressant)*
- Taking Charge of Diabetes® \* (age 18+)**
- Taking Charge of Your Heart Health® \* (age 18+)**  
 CAD     CHF
- Taking Charge of Asthma® (age 5-56)**  
Age:  5 – 9     10 – 17     18 – 56

**Case Management Referrals**

- End of Life Care Management**
- Frail Member**
- General Case Management**
- \_\_\_\_\_

To refer into Case Management call, fax this form *or* call **(800) 944-1211 Option 1** and provide the following:

- Your name and phone
- Member's name and ID#
- Reason for referral

\* Programs marked with an asterisk are available to Medicare PPO enrollees.

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**Overview of  
PacifiCare's  
Quality  
Improvement  
Program**

The purpose of PacifiCare's QI & UM Program is to objectively monitor, systematically evaluate and effectively improve the quality and safety of clinical care and service provided to Members. The program is designed to identify opportunities for improvement and activities, including care and service delivered by contracting primary care practitioners, specialty practitioners, health delivery organizations, behavioral health practitioners and supplemental providers.

The program and work plan ensure effective coordination of QI activities with all appropriate functional areas. The work plan identifies goals, objectives and planned activities that address the quality and safety of clinical care and service. Action steps include target dates for completion and identification of responsible parties. Monitoring activities include tracking and trending of previously identified issues and planned interventions.

PacifiCare has a prospective, concurrent and retrospective program. Data are systematically collected on clinical and service performance, analyzed, summarized and presented with recommendations to the QIC and its sub-committees. The identification of opportunities for improvement, which comes through continuous monitoring activities, leads to interventions designed to improve the overall plan performance in relation to the quality and safety of clinical care and service provided to Members.

PacifiCare requires practitioner's/provider's participation and cooperation with the Plan's QI Program. PacifiCare personnel and practitioners/providers are responsible for identifying, documenting and reporting risk management and potential quality of care issues. Identified issues are investigated, with all results tracked and trended.

*Additional information regarding PacifiCare's QI & UM Program and progress towards goals is communicated through the provider newsletter, QUALITY INDEX<sup>®</sup> profiles and upon request from your Network Management representative.*

**Clinical QI  
Initiatives**

DM initiatives address the healthcare needs of our entire population, and target common medical conditions that occur frequently among our membership. Many of the initiatives involve collaboration with academic and professional experts in quality of clinical care and improvement.

**Preventive  
Health &  
Clinical  
Practice  
Guidelines**

Preventive Health Recommendations and Clinical Practice Guidelines provide the basis for PacifiCare's Disease Management programs.

Preventive Health Recommendations/Guidelines are based on the U.S. Preventive Health Services Task Force, the American Academy of Pediatrics recommendations and the CDC Advisory Committee on Immunization Practices.

Clinical Practice Guidelines are evidence-based promulgated to help practitioners and Members make decisions about specific clinical situations. Nationally recognized guidelines and standards are utilized as major sources in the development of PacifiCare's guidelines. PacifiCare's guidelines include, but are not limited to, the following:

- Outpatient management of asthma
- Outpatient management of cardiovascular disease prevention for women
- Outpatient management of congestive heart failure
- Outpatient management of coronary artery disease
- Guidelines for the treatment of major depressive disorder
- Diabetes management

*To view PacifiCare's Clinical Practice Guidelines and/or Preventive Health Recommendations, please refer to the Medical Management Guidelines Manual on the Provider Portal and/or the Member web sites under the Resource Library. PacifiCare's Behavioral Health Guidelines are available online at [www.pbhi.com](http://www.pbhi.com). Copies can be downloaded from the web sites or contact your Network Management representative.*

**Preventive  
Health  
Initiatives**

Women's Health Initiatives

This initiative includes sending educational materials to eligible Members to remind them of the importance of cancer screenings.

Children's Health Initiatives

Interventions are designed to provide parents of newborns and adolescent children with information reminding them of the importance of immunizations and a schedule showing recommended timeframes.

Flu Prevention Initiatives

This initiative includes interventions designed to remind commercial Members at risk and senior Members to get annual influenza immunizations.

**Disease  
Management  
Initiatives**

PacifiCare has established Health Management (HM) and Disease Management (DM) programs designed to identify and manage Members diagnosed with certain chronic and catastrophic diseases. Many of the programs involve collaboration with academic and professional experts in quality of clinical care improvement.

The primary goal in these programs is to make measurable differences in Members' lives and to promote self-care. PacifiCare believes that Members can be full partners in managing their health when provided appropriate information and support for using it. PacifiCare may modify existing programs and/or add or delete certain programs and program requirements from time to time.

Success of these programs requires a collaborative work effort with our practitioners/providers. Practitioners/providers are asked to refer appropriate Members directly to PacifiCare's DM programs and participate and cooperate with DM program requirements for enrollment, ongoing performance and reporting of data, as established by PacifiCare.

**Population  
Based HM  
Programs**

PacifiCare offers population based health management programs to all eligible Members. *(Not all HM/DM programs are available in all states or for all products; call 800-915-9159 for additional information.)*

Taking Charge Of Depression<sup>sm</sup>: This 6-month program includes telephonic support, educational materials and self-care tools for Members who are diagnosed with a new or recurring episode of depression and prescribed antidepressants. This is an "opt-in" program. To enroll, Members can self-refer or be referred by their provider.

**Population Based HM Programs Continued**

*Taking Charge Of Diabetes<sup>sm</sup>*: This program addresses both self-care and lifestyle issues to help prevent diabetes complications. It includes education on lifestyle changes and information on preventive care, such as retinal eye exam and other tests. This program provides Members with mail-based or online education, preventive care reminder calls, tools and resources. This is an “opt-out program”. Members identified with diabetes are automatically enrolled in the program. They may opt-out, should they choose not to participate, by return mail opt-out card or by calling 800-915-9159.

*FREE & CLEAR<sup>®</sup> StopSmoking<sup>TM</sup>*: This 12-month self-paced smoking cessation program is designed to support members to succeed with their smoking cessation efforts. The program includes telephonic support and interactive Member materials. Smoking cessation aids can also be used. An accelerated program designed for expectant mothers is also available. This is an “opt-in” program. To enroll, members can self-refer or be referred by their provider.

*Taking Charge Of Your Heart Health<sup>sm</sup> - CAD, Taking Charge Of Your Heart Health<sup>sm</sup> - CHF* The Taking Charge of Your Heart Health<sup>SM</sup> programs provide self-directed interventions, addressing both self-care and lifestyle areas that are designed to improve the care for Members with congestive heart failure and those who have had a heart attack or heart-related procedure. The programs provide Members with mail-based or online education, tools and resources. These are opt-out programs. Members meeting program criteria are automatically enrolled. They may opt-out should they choose not to participate.

*Taking Charge Of Asthma<sup>®</sup>*: The Taking Charge of Asthma<sup>®</sup> program is a self-directed educational program focused on improving the understanding of the disease and compliance with treatment for commercial Members, of ages 5-56 years old. Interventions consist of mail-based or online education, tools and resources. This is an opt-out program. Members meeting program criteria are automatically enrolled. They may opt-out should they choose not to participate.

*Taking Charge Of Fitness*: The Taking Charge of Fitness program is a self-directed educational program focused on providing helpful information on weight, nutrition and fitness. Commercial Members who are identified by the Health Risk Assessment with a body mass index (BMI) of greater than 25 will automatically be enrolled into the program and receive program materials online. Senior members, identified by the Secure Horizons Member Health Questionnaire, with a BMI of 30 or greater automatically receive educational material by mail. This is an opt-out program. Members may opt-out, should they choose not to participate.

**Case Based  
DM Programs**

PacifiCare works with Alere Medical, Inc., to provide these case-based DM programs. To refer a PacifiCare Member or check their eligibility for current and/or future participation in a program, please call 877-840-4085. *(Not all programs are available in all states or for all product)*

Congestive Heart Failure (CHF) Program: PacifiCare's CHF program provides technology that connects doctors, Members and data. The program is designed to be a "virtual house call" and equips physicians with immediate and vital information from Members with Stage C<sup>1</sup> or Stage III<sup>2</sup> CHF and educates Members on managing their disease. The CHF Program combines a customized education plan, with the use of its DayLink™ monitor (a precision electronic scale, speaker and communications device) and staff of nurses to monitor a member's weight and physical symptoms and notify the patient's physician about clinical changes the patient is experiencing, along with empowering the members to be active participants in managing their disease.

<sup>1</sup> ACC/AHA Practice Guidelines, 2005

<sup>2</sup> NYHA Practice Guidelines

Coronary Artery Disease (CAD)/Stroke Program: The CAD program is designed to provide physicians with evidence-based recommendations to manage the care of their patients (Medicare Advantage Members only) with CAD and/or stroke and to address the underlying risk factors that contributed to the disease, such as hyperlipidemia or hypertension. This program focuses on compliance with evidence-based guidelines regarding treatment of the underlying risk factors leading to coronary artery disease and stroke, including cholesterol management, blood pressure management, blood glucose control, medications post-heart attack and lifestyle modifications. Objective and subjective data are analyzed and compared to national guidelines, with recommendations provided based on those guidelines. Educational materials are provided and members are encouraged to participate in PacifiCare's StopSmoking program as appropriate.

COPD Program: Following the GOLD Guidelines of the National Heart Lung and Blood Institute, this program establishes a collaboration to coordinate care for members with COPD. Symptoms and lung measurement functions are assessed and members receive education about how to avoid and control respiratory triggers. A treatment plan is established, and follow-up care is provided. Identified members are contacted for an initial telephone assessment of symptoms and quality of life related information.

**Case Based  
DM Programs  
Continued**

Based on this assessment, members are enrolled in one of three intervention types – educational materials, telephonic visit, or home visit. In conjunction with the member’s treating physician(s), respiratory therapists determine interventions based on a member’s symptoms, compliance and preferences. Members may move between program levels as necessary.

End Stage Renal Disease (ESRD) Program: This program provides education to Members regarding management of their renal disease and other co-morbidities. Each Member receives a case management assessment in the dialysis center or at home. The program includes an initial assessment (usually at the dialysis center or telephonically) and communication with the Member’s nephrologist and dialysis clinic regarding Member-specific care. Members are assigned a renal nurse case manager who assesses the member’s needs and develops an individual care plan. The case manager acts as a liaison to assure that communication and coordination of care is maintained with the nephrologists and other specialty providers. The case manager follows each patient when hospitalized and is actively involved in discharge planning and facilitation of early discharge. Clinical outcomes are improved through anemia management, nutritional improvement, vascular access and reduction of complications. The Program excludes pediatric patients.

Neonatal Intensive Care Unit (NICU) Program: Neonatal nurses facilitate continuity of service and care, promote family involvement, and facilitate the baby’s successful discharge and transfer home. Network neonatologists are supported in their role as clinical decision-makers and optimize family involvement in the baby’s care while in the NICU. The collaborative, neonatologist-directed program provides NICU-trained registered nurse care managers who perform concurrent review for those neonates, interact regularly with the NICU’s medical staff, and educate and support families.

Cancer Program: This program is for Commercial PacifiCare Members in active treatment for cancer. Oncology-trained, licensed nurse care managers provide coordination of care, education and support to Members and their families to help prevent complications and improve symptom management. The proactive telephonic care management process provides a bridge between office visits by monitoring the Member’s response to, and compliance with, the treatment plan. The care manager communicates pertinent information about the Member to the treating physician’s office.

**Diversity  
Initiatives**

The purpose of PacifiCare's Strategic Diversity Initiative is to tailor disease management programs, services and materials to meet the cultural and linguistic needs of diverse populations.

The following programs have been implemented by PacifiCare:

- Latino Health Solutions
- African-American Health Solutions
- Asian-American Health Solutions
- Women's Health Solutions

PacifiCare has enhanced these programs by contracting with telephonic interpretive services and by developing web sites and Member materials in other languages in order to give Members with special language needs more information about their health plan and benefits.

**Service  
Quality  
Improvement  
Initiatives**

Ensuring Member satisfaction is the primary function of PacifiCare's Service Solutions Committee (SSC). The SSC routinely monitors Member satisfaction surveys, complaints, and appeals. The Committee also oversees ongoing quality improvement activities for key areas of dissatisfaction. PacifiCare has identified opportunities and implemented initiatives to improve:

- Member satisfaction with access to care
- Practitioner satisfaction with the UM process
- Timeliness of the claims process

**Access &  
Availability to  
Medical &  
Behavioral  
Health  
Services**

PacifiCare monitors Members' access to medical and behavioral healthcare to ensure that PacifiCare has an adequate provider network to meet the Member's healthcare needs. PacifiCare utilizes Member satisfaction surveys and Member complaints to assess performance against standards.

- Routine Appointment: *How much of a problem was it to get a routine appointment as soon as the Member wanted it?* (**Guideline:** Routine appointments should be within thirty (30) days of request for medical care and within ten (10) days of request for behavioral healthcare).

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**Access &  
Availability to  
Medical &  
Behavioral  
Health  
Services  
Continued**

- Preventive Care Appointment: *How much of a problem was it to get a Preventive Care Appointment as soon as the Member wanted it?* (**Guideline**: Routine appointment should be within thirty (30) days of request for medical care).
- Office Wait Time: *Did the Member have to wait less than thirty (30) minutes from the time of the appointment to see the practitioner?* (**Guideline**: The Member should wait less than 30 minutes from the time of their appointment until they are with the physician in the exam room).
- Illness or Injury: *When the Member needed care right away, did the Member get needed care as soon as they wanted for an illness, injury, or condition?* (**Guideline**: Access to Emergency Care should be immediate. Access to Urgent Care should be within twenty-four (24) hours of the request. Access to non-urgent, symptomatic care should be within 7 calendar days of the request).
- After Hours Access to Care: *When the Member called after regular office hours, how often did they get the help or advice they needed?*
- (**Guidelines**: 1) either a live person or answering machine should answer and respond to calls, 2) the Member should be directed to emergency care, 3) the Member should be directed to leave a phone number for a call back, 4) the physician should call back within thirty to sixty (30-60) minutes).
- Specialist Appointment: *How much of a problem was it to get an appointment with a specialist the Member wanted to see?* (**Guideline**: Whether the approval is made at PacifiCare or at the delegated Medical Group/IPA, the referral process turnaround and notification to the Member should be within fourteen (14) days of request. Routine appointments should be within thirty (30) days of request).
- Getting Needed Care, Tests or Treatment: *How much of a problem, if any, was it to get the care, tests or treatment the Member or Doctor believed necessary?* (**Guideline**: Whether the approval is made by PacifiCare or by a delegated Medical Group/IPA, the referral process turnaround and notification to the Member should be within fourteen (14) days of request).

**Access &  
Availability to  
Medical &  
Behavioral  
Health Services  
Continued**

- Delays in Care While Waiting for Approval: How much of a problem were delays in healthcare while you waited for approval? (Guideline: Whether the approval is made at PacifiCare or the delegated Medical Group/IPA, the referral process turnaround and notification to the Member should be within fourteen (14) days of request).

NOTE: The guidelines listed above are general PacifiCare enterprise-wide guidelines; State regulations may require more stringent standards. Contact your Network Management representative for State- specific regulations.

**Cultural &  
Linguistic  
Services**

There is a growing body of evidence that cultural and language barriers have a direct impact on healthcare delivery and healthcare outcomes. Effective medical management is contingent upon clear communication.

In accordance with State and Federal regulations, PacifiCare requires practitioners/providers to have policies and procedures that describe mechanisms to ensure Members/patients who are sensory impaired and/or have limited English proficiency skills have an equal opportunity to access and participate in all services.

Interpretative and/or auxiliary aide services must be made available, at no cost to the Member, upon request. Members have the right to a certified medical interpreter or sign language interpreter to translate health information accurately, who must respect the Member's privacy and keep all information confidential. Family and friends of limited English proficiency or hearing impaired Members shall be asked to provide interpretive services only after alternative methods have been explained and the Member still chooses this option.

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**Section C:                    Member Rights & Responsibilities Statement**  
**Measuring Provider Performance**  
**Member Satisfaction Surveys**

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**Quality Improvement**

**Revised: 11/2005**

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**Member Rights  
&  
Responsibilities  
Statement**

PacifiCare has established a Member Rights & Responsibilities policy based on regulatory and accreditation standards to affirm our commitment to treating our Members in a manner that respects their rights and lists our expectation of their responsibilities. PacifiCare's Member Rights and Responsibilities (MR&R) Statement is reviewed and updated annually and communicated to our Members and practitioners/providers.

*Copies of the current MR&R Statement are available at the end of this section and on the Provider Portal and Member web sites. Paper copies are available, upon request, from your Network Management representative.*

**Measuring  
Provider  
Performance**

An evaluation of the overall effectiveness of the QI Program is conducted annually to determine how well resources have been deployed to improve the quality and safety of clinical care and service provided to Members. The evaluation addresses all aspects of the quality improvement process as outlined in the Program and is presented to the QI Committee for review, discussion and approval. The Board of Directors reviews and approves the Annual QI Program and Evaluation. Performance is measured using a variety of metrics.

**Member  
Satisfaction  
Surveys**

Member satisfaction with the quality of care and service is monitored by the annual Consumer Assessment Health Plan Survey (CAHPS<sup>®</sup>) survey. PacifiCare contracts with an NCQA certified vendor to conduct the annual survey. Members rate their satisfaction in multiple areas, including: overall satisfaction with the health plan, their healthcare, primary care practitioner, specialist, appointment access and customer service.

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**Member  
Complaints &  
Appeals**

PacifiCare monitors and analyzes Member complaints and appeals to identify opportunities for improvement and to develop and implement QI initiatives. Member complaints are received by telephone call to Customer Service, by written correspondence and by submission on the plan web sites. All complaints are coded and entered into a centralized system. This information is linked to Member and provider demographic information to facilitate analysis, identification of trends and opportunities for improvement.

**QUALITY  
INDEX®  
Profile of  
Hospitals**

The QUALITY INDEX® *Profile of Hospitals* is PacifiCare's public report on hospital performance. Hospitals in the PacifiCare contracted network have long demonstrated successful programs, such as maintaining accreditation by external agencies, compliance with Federal and State regulations, and impressive quality initiatives. Yet, among this elite network of hospitals, differences in performance exist. As an integral part of PacifiCare's overall quality improvement program, this unique report measures the clinical and service performance of participating hospitals on over 55 measures. (Not available in all states.)

*Copies of the QUALITY INDEX® Profiles are available on the Provider Portal and Member web sites. Paper copies are available, upon request, from your Network Management representative.*

**Confidentiality  
& HIPAA**

All employees, contracting practitioners/providers and agents of PacifiCare are required to maintain the confidentiality of Member information, i.e., medical record, peer review and quality improvement records. All Member information is maintained as confidential in accordance with Federal and State laws and regulations.

- Participation on all QI committees requires a signed Confidentiality Agreement. This agreement allows free, candid and objective discussion necessary for effective management. Access to Member or practitioner-specific peer review information is restricted to those individuals and/or committees charged with responsibility for peer review activities.

**Confidentiality  
& HIPAA  
Continued**

Health Insurance Portability and Accountability Act (HIPAA) is the most significant body of healthcare legislation enacted since the implementation of the Medicare Program. HIPAA regulations apply to all insurers and health plans, healthcare providers who exchange electronic transactions and clearinghouses that are used to support electronic transactions.

The purpose of HIPAA is to provide the following protections for the use and disclosure of Protected Health Information (PHI):

- requires covered entities to inform consumers about how their health information will be used and/or disclosed;
- defines how PHI may be used or disclosed;
- places restrictions on the amount of information used and disclosed to the “minimum necessary”;
- limits the release of PHI without authorization;
- gives patients access to their own health records and the right to request amendments and/or make corrections;
- establishes administrative requirements for implementation of the Privacy Rule.

**Patient /  
Member  
Rights**

The Privacy Rule grants patients greater control over their PHI and allows them to exercise the following PHI related rights:

- amend their PHI;
- request an accounting of disclosures of PHI for purposes other than treatment, payment or health care operations;
- receive a copy of the entity’s Notice of Privacy Practices;
- inspect and copy their PHI;
- request restrictions regarding the use/disclosure of their PHI;
- request alternate or confidential communications;
- file a complaint if they believe there has been a violation of their privacy rights.

**Protected  
Health  
Information  
(PHI)**

Protected Health Information (PHI) is defined as individually identifiable health information that is transmitted or maintained in any form or medium. The definition covers information that is transmitted or maintained electronically, in paper records or via oral communications.

**Treatment,  
Payment or  
other Health  
Care  
Operations  
(TPO)**

Treatment

- consultations, referral and coordination with third parties;
- disclosures to ancillary or specialty care services that may be requested by a provider for the purposes of treatment.

Payment

- determination of eligibility for coverage;
- risk adjustment activities based on enrollee health status and demographic characteristics;
- billing, claims management collection activities and obtaining payment under contract for reinsurance;
- disclosure to consumer reporting agencies of PHI relating to the collection of premiums or reimbursement.

Health Care Operations

- quality assessment and improvement activities;
- provider and health plan performance measurement;
- complaint, grievance and appeal investigation;
- case, utilization and disease management activities;
- administrative and legal requirements.

**Use &  
Disclosure**

HIPAA permits covered entities to use and/or disclose PHI for the purposes of TPO.

Authorization is **not required** for certain activities that fall outside the scope of TPO. These exceptions include the following activities: public health, law enforcement, government agency health oversight, worker's compensation, situations involving abuse, violence or neglect and civil and criminal hearings.

Authorization is **required** for use and disclosure of: psychotherapy notes, fundraising and certain types of research and marketing activities.

**Business  
Associate  
Agreements**

Practitioners/providers shall establish policies and procedures to protect patients from unwarranted use and disclosure of individually identifiable health information.

- define a process for identifying business associates;
- create a process to obtain business associate contracts;
- prepare a policy through which the practitioners/providers can enforce contract termination for continued inappropriate use and/or disclosure of PHI.

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**Quality Improvement****Revised: 11/2005**

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**Notice of  
Privacy  
Practices**

Healthcare organizations and practitioners/providers are now obligated to explain to their patients (by issuing a Notice of Privacy Practices) how their information will be used and disclosed. (The Department of Health and Human Services has mandated language that must be included in the notice, as well as specific distribution requirements.)

Covered entities must provide a Privacy Notice:

- no later than the date of the first service delivery;
- have notice available at physical delivery site;
- post notice in a clear and prominent location;
- upon revision, make notice available.

*PacifiCare's Notice of Privacy is available on the Provider Portal and Member web sites. Paper copies are available, upon request, from your Network Management representative. For additional information, go to the Department of Health and Human Services web site at: [www.aspe.hhs.gov/admnsimp/index.shtml](http://www.aspe.hhs.gov/admnsimp/index.shtml) or the HIPAA Advisory web site at [www.hipaadvisory.com](http://www.hipaadvisory.com).*

**Administrative  
Rules**

Practitioners/providers must comply with the following HIPAA Privacy Rule administrative requirements:

- assign a Privacy Official;
- document "minimum necessary" requirements;
- have, apply and document sanctions against practitioner/provider staff who violate the rules;
- provide and document training of all employees;
- ensure there is a comprehensive complaint system;
- develop/revise policies and procedures.

**National  
Privacy  
Officer**

PacifiCare has designated a National Privacy Officer who is responsible for ensuring enterprise-wide development, implementation and compliance with these policies.

**Medical  
Records**

PacifiCare requires practitioners/providers to have written policies and procedures regarding medical record keeping practices and documentation standards, confidentiality and access to medical records. The goal of these policies is to ensure that medical records are maintained in a manner that is current, detailed, organized and permits effective and confidential patient care and quality review.

Medical record documentation is used by PacifiCare and regulatory entities to assess the quality of care and in the resolution of grievances and appeals. The medical record is a legal document subject to discovery during litigation.

**Medical records must reflect all services provided by the practitioner, including diagnostic tests, ancillary services, hospital discharge summaries and education and preventive health services.**

Medical records are reviewed by PacifiCare at least annually, using a variety of methods. Overall analysis is conducted with comparisons to performance goals. Opportunities for improvement are identified and interventions are implemented as needed.

*PacifiCare's Medical Record-Keeping Practices and Documentation Standards are listed at the back of this section.*

**Confidentiality  
of Medical  
Records**

Practitioners/providers are required to have policies and procedures regarding:

- safeguarding medical record confidentiality;
- release of medical records in accordance with State and Federal law;
- informing Members when requesting medical records for outpatient services received from a psychotherapist via informed consent, waiver of notification or written notification.

**Access to  
Medical  
Records**

Practitioners/providers must provide access to medical records under the following conditions:

At time of appointment: In addition to assuring that medical records are maintained in a confidential manner, Member's medical records must also be available at the time of an appointment. Practitioners/providers must have systems for

**Access to  
Medical  
Records  
Continued**

retrieving, archiving, purging and disposing of records to ensure availability and confidentiality.

To Member/Patient: Members may access their medical records at any time. Members shall be given the opportunity to review their medical records in a timely fashion.

To PacifiCare: Medical records of PacifiCare Members must be available to PacifiCare representatives, upon request, for HEDIS<sup>®</sup> data collection, quality assessment, improvement and utilization management activities, investigation of complaints, grievances and appeals, and peer review purposes.

**Advance  
Directives**

Practitioners/providers should inform Members of their right to make healthcare 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 are several types of Advance Directives that the Member can choose, depending on State law. Most states recognize General Power of Attorney, Durable Power of Attorney for Health Care, Living Wills and Natural Death Act Declarations.

The Federal Patient Self-Determination Act requires practitioners/providers to have written policies and procedures that address the following:

- Provide written information to each adult patient concerning their right to make decisions regarding his/her healthcare;
- Document in the patient's medical record whether or not the individual has executed an Advance Directive. If the patient has executed an Advance Directive, a copy of the document must be prominently displayed in the record;
- Ensure compliance with all applicable State laws;
- Provide for education of staff/practitioners concerning Advance Directives, and responsibilities thereof;
- Allow a Member's representative to manage care or treatment decisions when a Member is incapacitated or unable to do so;
- Allow a Member or a Member's representative to be involved in decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment.

**Advance  
Directives  
Continued**

All Members/patients must be informed of their right to make choices about their medical treatment, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive. Practitioners/providers must inform Members of their medical condition and all available treatment options, including treatments which may not be a covered benefit under the Member's health plan. In addition, patients must be informed of the risks and benefits of each treatment option.

The medical record must have documentation, in a prominent part of the medical record, indicating whether or not the patient has executed an Advance Directive. Practitioners/providers may not make treatment conditional or otherwise discriminate on the basis of whether an individual has executed an Advance Directive.

Medicare law gives Members the right to file a complaint with the State Survey and Certification Agency if the Member is dissatisfied with the organization's handling of Advance Directives and/or if a practitioner or provider fails to comply with Advance Directive instructions. The Member's State agency is listed in their Evidence of Coverage.

*For additional information, go to the following web site:  
[www.partnershipforcaring.org](http://www.partnershipforcaring.org)*

## Member Rights & Responsibilities Statement

As a Member/Enrollee you have the right to receive information about, and make recommendations regarding, your rights and responsibilities.

### **You have the right to:**

#### *Timely, Quality Care*

- Discuss and actively participate in decision-making with your Contracting Provider regarding the full range of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Refuse any treatment or leave a medical facility, even against the advice of a Contracting Provider. Your refusal in no way limits or otherwise precludes you from receiving other Medically Necessary Covered Services for which you consent.
- Without discrimination, submit complaints regarding PacifiCare or Contracting Providers or request appeals for services denied by PacifiCare or by Contracting Providers.

#### *Treatment with Dignity and Respect*

- Be treated with dignity and respect and have your right to privacy recognized in accordance with state and federal laws.
- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your health care.
- Complete an Advance Directive, living will or other directive and provide it to your Contracting Provider to include in your medical record. Treatment decisions are not based on whether or not an individual has executed an advance directive.

#### *Information about PacifiCare and Contracting Providers*

- Receive information about PacifiCare and the Covered Services under your plan/policy.
- Receive information about the Contracting Providers involved in your medical and behavioral health treatment, including names and qualifications.
- Request information about our Quality Improvement Program, its goals, processes and/or outcomes.

### **Your Responsibilities Are To:**

- Review information regarding your benefits, Covered Services, any exclusions, limitations, deductibles or Copayments, and the rules you need to follow as stated in your Evidence of Coverage/Certificate.
- Provide PacifiCare and Contracting Providers, to the degree possible, the information needed to provide care to you.
- Follow treatment plans and care instructions as agreed upon with your Contracting Provider. Actively participate, to the degree possible, in understanding and improving your own medical and behavioral health condition and in developing mutually agreed upon treatment goals.
- Accept your financial responsibility for Health Plan Premiums, any other charges owed, and any Copayment or Coinsurance associated with services received while under the care of a Contracting Provider or while a patient in a facility.

## Member Rights & Responsibilities Statement Continued

If you have questions or concerns about your rights, please call Customer Service at the phone number listed on the back of your membership card. If you need help with communication, such as help from a language interpreter, Customer Services representatives can assist you. [Secure Horizon members can also get free help and information from their State Health Insurance Assistance Program or SHIP which is listed in their Evidence of Coverage and on the PacifiCare websites. In addition, the Medicare program has written a booklet called Your Medicare Rights and Protection. To get a free copy call 1-800-MEDICARE (1-800-633-4227) or TTY (1-877-486-2048). Or you can access the Medicare web site at [www.Medicare.gov](http://www.Medicare.gov) to order this booklet or print it directly from your computer.]

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## Medical Record-Keeping & Documentation Standards

Medical Record-Keeping Standards: Practitioners are required to provide evidence that:

1. medical records are organized in such a manner as to facilitate prompt retrieval
2. there is a formal system for record format/layout
3. there is a system for posting of reports in medical records
4. there is a formal mechanism describing turnaround time for dictation to be placed in record
5. there is a formal mechanism describing turnaround time for hospital records to be placed in record
6. there is a mechanism for monitoring and handling missed appointments

Documentation Standards: Medical Records are evaluated against these standards. Audit tools may vary state to state but a performance threshold of 85% is expected to show compliance with standards.

1. Each page contains the patient's name or ID number.
2. Personal Data includes address, employer, home, work telephone numbers, marital status
3. All entries contain Author Identification which may be handwritten, an initials-stamped signature, or a unique electronic identifier.
4. All entries are Dated
5. The record is Legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on the Problem List.
7. Prescribed medications, including dosages, dates of initial or refills are documented.
8. Medication Allergies and adverse reactions are prominently noted in the record as well as lack of allergies or adverse reactions.
9. Past Medical History (for patients seen >3 times) is easily identified and includes serious accidents, operations, and illnesses. For children less than 18 years old, past medical history relates to prenatal care, births, operations and childhood illnesses.
10. For patients 14 years and older there is appropriate notation concerning use of cigarettes, alcohol, or Substance Abuse (for patients seen >3 times, query substance abuse history).
11. The History and Physical exam identifies appropriate subjective and objective information pertinent to patient's presenting complaints.
12. Working Diagnoses are consistent with findings.
13. Treatment Plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, when indicated regarding Follow-Up Care, calls or visits. The specific time of return is noted in weeks, months or as needed.
15. Unresolved Problems from previous office visits are addressed in subsequent visits.
16. There is no evidence of Under or over Utilization of consultants.
17. Laboratory and other studies are ordered, as appropriate.
18. Evidence of Continuity of Care between PCP and specialists, i.e., if a Consultation was requested, there is a note from the consultant, and/or evidence from hospitals, skilled nursing facilities, home health agencies, and ambulatory surgery centers. .
19. Consultation, lab and imaging Reports Filed in chart are Initialed by practitioner to signify review. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans for abnormal results. (Review and signature by professionals other than PCPs, such as nurse practitioners and physician assistants, do not meet this requirement. If the reports are presented electronically, or by some other method, there is also representation of physician review.)
20. For members referred to Behavioral Health Services, there is documentation of patient-approved exchange of information between PCP and Behavior Health practitioners.
21. There is no evidence in the medical record that the patient is placed at Inappropriate Risk by a diagnostic or therapeutic problem.

## Medical Record-Keeping & Documentation Standards Continued

22. Immunization Records for children are up to date or an appropriate history has been documented in the medical record for adults.
23. There is evidence of Preventive Screening and services offered in accordance with PacifiCare practice guidelines.
24. Advance Directive information is offered and documented in a prominent part of the member's medical record, as well as documentation on whether or not a member has executed an advance directive.

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**Section D:**

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**Emergency Services Procedure**

**Revised: 06/2005**

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Emergency Condition Definition..... D-1

**Emergency  
Condition Definition**

Emergency services are covered services required by a covered person 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 insured in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part;
4. Active labor, meaning labor at a time that either of the following would occur:
  - Inadequate time to effect safe transfer to another hospital prior to delivery; or
  - Transfer may pose a threat to health and safety of patient or unborn child.

**Credentialing Program****Revised: 06/2005**

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**Credentialing  
Program****Periodic Review**

PacifiCare has a comprehensive, written credentialing program which has been established in accordance with the standards of the National Committee for Quality Assurance (NCQA) and applicable State and Federal regulatory requirements that is reviewed and revised at least annually.

**Purpose**

PacifiCare maintains written standards and policies and procedures for credentialing and recredentialing of participating practitioners, hospitals and other healthcare professionals and facilities that provide medical services to covered persons. The credentialing program is maintained in accordance with the requirements of State and Federal laws.

**Credentialing  
Requirements**

PacifiCare requires participating practitioners to meet the minimum credentials, qualification and criteria established by PacifiCare. A practitioner's credentialing information is verified for the following:

- Current, valid, unrestricted state license to practice medicine;
- Current, valid Drug Enforcement Agency (DEA) certificate and current state controlled substance certificate, where applicable;
- Current malpractice liability insurance;
- Education;
- Training, in practicing specialty;
- Board Certification, if applicable;
- Hospital staff privileges, where applicable;
- History of malpractice actions;
- Review of Curriculum Vitae for previous five (5) years of work history;
- Signed and dated Attestation Statement.

**Credentialing  
Scope**

PacifiCare's credentialing program applies to:

- Allopathic physicians (MDs)
- Osteopathic physicians (DOs)
- Dentists (DDSs) providing medical care
- Podiatrists (DPMs)
- Chiropractors (DCs)
- Behavioral Health (MDs, PhDs, LCSWs, etc.)
- Other licensed independent practitioners who are approved to provide services to PacifiCare PPO insured outside the inpatient setting and who are listed in the PacifiCare Provider Directory furnished to insured

**Recredentialing**

PacifiCare performs recredentialing of its practitioners at least every three (3) years. Recredentialing materials are distributed to practitioners and are required to be completed and returned within a specified timeframe. Failure to return the requested information in the established timeframe may result in the termination of the Participating Provider Agreement.

**Provider  
Licensing /  
Certification  
Requirements**

The practitioner will maintain licenses, certificates and/or approvals required under State and Federal law for the performance of services.

**Practitioner  
Qualifications**

All practitioners will be reviewed against the following criteria and qualifications:

- Current, valid, unrestricted license to practice his/her profession;
- Current, valid Drug Enforcement Agency (DEA) certificate, if applicable;
- Current, valid state controlled substance certificate, if applicable;

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**Credentialing Program****Revised: 06/2005**

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**Practitioner  
Qualifications  
Continued**

- Board certification or adequate professional experience, education and training in the requested area of practice;
- Satisfactory history with respect to employment;
- Absence of felony convictions;
- Adequate physical and mental health status (subject to any necessary reasonable accommodation);
- Absence of current illegal drug use;
- Adequate professional liability insurance as specified in the practitioner's contract;
- Willingness to participate in and properly discharge professional responsibilities, including adherence to PacifiCare peer review, utilization management and quality management programs;
- Satisfactory history with respect to State and Federal licensing agencies, medical staff membership or clinical privileges, disciplinary actions, Medicare/Medicaid sanctions or any other actions reasonably related to his/her professional judgment, competence and clinical/technical performance;
- Satisfactory history with respect to malpractice claims.

**Non-Discrimination**

The credentialing and recredentialing process does not allow for decisions based solely on an applicant's race, ethnic/national identity, gender, age or sexual orientation. Additionally, selection and retention criteria do not discriminate against healthcare professionals who serve high-risk populations or those who specialize in treating costly conditions.

**Network and  
Business Needs**

The network and other business needs of PacifiCare health plans are considered, along with the practitioner's professional credentials and qualifications, in making decisions whether to approve or deny the application or reapplication of the practitioner to provide healthcare services to PacifiCare Members.

**PacifiCare's  
Discretion**

The credentialing criteria, standards and requirements set forth in this Manual are not intended to limit PacifiCare's discretion in any way or to create rights on the part of practitioners who seek to provide healthcare services to PacifiCare Members.

**Confidentiality**

PacifiCare staff maintains the confidentiality of all information obtained about practitioners in the credentialing and recredentialing process, as required by law. Only Credentialing Staff, Credentialing Committee Members, Medical Directors and other authorized persons who must have access to confidential practitioner credentialing and recredentialing information in order to perform their functions relating to credentialing and recredentialing of practitioners have access to such information. PacifiCare staff or representatives do not disclose confidential practitioner credentialing and recredentialing information to any persons or entity except with the express written permission of the practitioner or as otherwise permitted or required by law.

**Practitioner  
Rights**

Practitioners are notified of the following rights through the credentialing and recredentialing applications:

**Right to review information** - Practitioners are notified of the right to review information obtained to evaluate the practitioner's application. The evaluation includes information obtained from any outside source (malpractice insurance carrier, state licensing boards, etc). This information does not include information protected by State or Federal law.

**Right to correct erroneous information** – Within five (5) business days of identifying any information obtained from other sources that vary substantially from the information provided by the practitioner, PacifiCare staff will notify practitioners verbally or in writing. Practitioners must provide a written or telephonic response to the requesting PacifiCare staff member within ten (10) business days. All responses will be documented in the practitioner's credentialing file.

**Practitioner Rights  
Continued**

Verbal responses will include the date and details of the conversation, the name of the person providing the information and the name or initials of the PacifiCare staff person documenting the conversation. PacifiCare is not required to reveal the source of the information if the information is not obtained to meet PacifiCare's credentialing requirements or if disclosure is prohibited by State and Federal laws.

**Right to be informed of application status** – Practitioners have a right, upon request, to be informed of the status of their application. Requests and responses may be submitted by telephone or in writing. Application status information is limited to the following:

- Not received
- Returned incomplete
- In process
- Committee ready
- Denied

**Verbal** – Approved is not synonymous with “Active.” Practitioners may not begin seeing PacifiCare Members until the practitioner has received written notification from PacifiCare’s Contracting department that the applicable contract has been activated.

**Right to Reapply**

Practitioners who have been denied initial credentialing may reapply under PacifiCare’s current criteria, no sooner than twelve (12) months from the date of the denial. PacifiCare reserves the right to review the applicant against all credentialing criteria applicable at the time of the reapplication.

**Initial  
Credentialing  
Process**

**Credentialing Application Form** - The applicant must submit a completed, signed and dated Credentialing Application Form (“application”), including an Attestation and Release. The applicant must provide all information requested on the application, documentation or any other requested information.

**Collection and Verification of Information** - Upon receipt of a completed application, the practitioner's professional credentials and qualifications are verified through primary sources of verification.

**Recredentialing  
Process**

**Every Three (3) Years** - Recredentialing is conducted every thirty-six (36) months (three (3) years). The recredentialing process identifies and evaluates any changes in the practitioner’s licensure, training, experience, current competence or health status that may affect the practitioner’s ability to perform the delivery of healthcare services.

**Recredentialing Application Form** – A recredentialing application is sent to each practitioner who falls within the scope of this policy. The practitioner must complete, sign and date the Recredentialing Application, including the Attestation and Release. The practitioner must provide all information requested on the application, documentation or any other requested information.

**Collection and Verification of Information** -- Upon receipt of a completed recredentialing application, the practitioner's professional credentials and qualifications are re-verified through primary sources of verification.

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**Section E:            Credentialing Committee Decision-Making Process****Credentialing Program****Revised: 06/2005**

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**Credentialing  
Committee  
Decision-Making  
Process**

Practitioners who meet PacifiCare’s established criteria are reviewed and approved by the chair of the Credentialing Committee, a PacifiCare board-certified physician. This physician may designate this activity to another PacifiCare Medical Director, as needed.

Practitioners who do not meet PacifiCare’s established criteria are presented to the Credentialing Committee. The information provided to the Credentialing Committee includes the practitioner’s profile, outlining his/her training, education, professional credentials and all documentation related to the issue or issues in question. The Credentialing Committee may request further information from any persons or organizations, including the practitioner, in order to assist the Committee with the evaluation process.

**Determination of Approval or Denial**

Upon completion of its review and evaluation of all the practitioner's credentialing information, including health status and all verifications of credentialing information from primary sources, the Credentialing Committee shall approve or deny the practitioner for participation.

The chair of the Credentialing Committee, a PacifiCare Medical Director, reviews and approves the practitioners who meet all of PacifiCare’s Credentialing/Recredentialing criteria. The chair or designee may bring cases to the Credentialing Committee, as needed, for further review prior to the approval or denial decision.

**Practitioner Notification**

For initial credentialing, practitioners are notified of the Credentialing Committee’s decision to approve or deny credentials within sixty (60) days of the committee’s decision. For recredentialing, practitioners are notified of a decision to terminate a practitioner’s participation within sixty (60) days of the committee’s decision.

**Credentialing  
Committee  
Decision-Making  
Process Continued**

**Notification to Authorities**

If a practitioner's participation is suspended or terminated based upon deficiencies in the practitioner's professional competence, conduct or quality of care, PacifiCare will submit any and all required reports to the National Practitioner Data Bank (NPDB) and the applicable State Licensing Board.

**Reactivating Terminated Practitioners**

If a practitioner has a break in his/her relationship with PacifiCare that lasts for a period of over thirty (30) consecutive calendar days, the practitioner will be considered a new applicant and must be credentialed before providing healthcare services to PacifiCare Members. Reasons for such a break in the relationship include, but are not limited to, the termination of the practitioner's contract with PacifiCare or the termination of the practitioner from a group under contract with PacifiCare. Where a practitioner has had a break in his/her relationship, only those elements that have expired or will expire according to regulatory or accreditation standards prior to Committee review are required to be re-verified. Re-verification of information not subject to change, such as education, is not required.

PacifiCare staff will evaluate available historical performance data of practitioners who terminate and re-apply, in order to ensure that professional performance, judgment and clinical competence was acceptable while providing services to PacifiCare Members.

**Listings in Practitioner Directories and Other Member Materials**

Information provided in Member materials, including practitioner directories, is consistent with the information obtained in the credentialing process.

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**Section E: Cred. Committee Decision-Making Process Cont. Delegation of Credentialing**

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**Credentialing Program**

**Revised: 06/2005**

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**Credentialing Committee Decision-Making Process Continued**

Information obtained during the credentialing process, including, but not limited to, education, training, certification and specialty(ies), is submitted to the appropriate department for data entry into the practitioner data systems for practitioner directories and other Member materials. Upon recredentialing, practitioner profiles are submitted for any needed changes and quality control procedures are followed in the same manner as initial credentialing.

**Delegation of Credentialing**

PacifiCare maintains standards, policies and procedures for credentialing and recredentialing of physicians and other licensed independent healthcare professionals, hospitals and other organizational provider facilities that provide medical services to our Members. PacifiCare may delegate credentialing activities to a Medical Group/IPA or Single Purpose Entity (i.e., Chiropractic, Vision, Therapy and Radiology management companies) that demonstrate compliance with standards for credentialing and recredentialing.

The Medical Group/IPA or Single Purpose Entity will maintain a written description of its credentialing program that documents the following activities in a format that meets PacifiCare's standards:

- Credentialing
- Recredentialing
- Assessment of contracted organizational providers
- Sub-delegation of credentialing, as applicable
- Review activities, including establishing and maintaining a Credentialing Committee and ongoing monitoring activities

**Delegation of  
Credentialing  
Continued**

The Credentialing Committee is the governing body responsible for developing and monitoring the following components of the credentialing program:

- Program description, policies, procedures and standards
- Credentialing providers
- Recredentialing providers
- Review activities

PacifiCare retains the right, based on quality issues, to approve, suspend and terminate individual practitioners, providers and sites in situations where it has delegated decision making.

**Delegation of  
Credentialing –  
Audit Process**

Credentialing may be delegated to a Medical Group/IPA or Single Purpose Entity that demonstrates compliance with PacifiCare's established standards for the credentialing function.

PacifiCare will perform an initial audit to ensure the Medical Group/IPA or Single Purpose Entity complies with PacifiCare's standards for delegation of credentialing. At least annually thereafter, PacifiCare will audit the Medical Group/IPA or Single Purpose Entity to ensure continued compliance. PacifiCare may initiate a focused audit based on specific activity at the Medical Group/IPA or Single Purpose Entity that warrants such an audit. If the Medical Group/IPA or Single Purpose Entity is an NCQA certified entity, PacifiCare may choose to waive applicable elements of the annual audit. However, the Medical Group/IPA or Single Purpose Entity may still be required to provide specific documents/evidence to the auditor, as applicable.

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**Section E: Delegation of Credentialing – Sanctions**  
**Delegation of Cred. – Profile & Reporting Requirements**

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**Credentialing Program**

**Revised: 06/2005**

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**Delegation of  
Credentialing –  
Sanctions**

Based on the compliance audit findings, PacifiCare may require the Medical Group/IPA or Single Purpose Entity to develop a corrective action plan designed to bring the provider back into compliance.

Providers who do not achieve compliance within the established timeframes may be sanctioned until such time as they achieve compliance. Credentialing is a delegated function that is subject to de-delegation.

Sanctions may consist of delegation with a corrective action plan or de-delegation.

There are costs to the Medical Group/IPA or Single Purpose Entity should the provider become de-delegated.

**Delegation of  
Credentialing –  
Profile and  
Reporting  
Requirements**

PacifiCare requires all Medical Groups/IPAs and Single Purpose Entities to adhere to the following standards for physician notification procedures. The Medical Group/IPA or Single Purpose Entity shall provide prior written notice to PacifiCare of the addition of any new physicians. Notice shall include credentialing information on all new physicians accepted and approved by the Medical Group/IPA or Single Purpose Entity, as well as any changes to current physician profiles, including the following:

- License
- DEA registration
- Work history/Curriculum Vitae
- Education
- Training
- Current malpractice liability insurance coverage face sheet
- List of hospitals with admitting privileges
- Generic agreement between the Medical Group/IPA and contracted providers, including a copy of the signature page from each provider

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**Section E: Delegation of Cred – Profile & Reporting Reqs. Cont.**  
**Delegation of Credentialing – Semi-Annual Reporting**  
**Delegation of Cred – Physician Negative Actions Reporting Reqs.**

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**Credentialing Program**

**Revised: 06/2005**

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**Delegation of  
Credentialing –  
Profile and  
Reporting  
Requirements  
Continued**

- Billing information – to include:
  - a) Legal entity name
  - b) Billing address
  - c) Tax identification number or Social Security number
  - d) Copy of W-9
- Product participation (i.e., PacifiCare, Secure Horizons)
- Certificate from the American Board of Medical Specialties (ABMS) or the American Osteopathic Specialty Board (AOSB), if board certified, or
- Certificate of completion of residency or fellowship showing specialty training

**Delegation of  
Credentialing –  
Semi-Annual  
Reporting**

At a minimum, on a semi-annual basis, the Medical Group/IPA or Single Purpose Entity will provide PacifiCare with reports identifying which practitioners have been credentialed and recredentialed.

**Delegation of  
Credentialing –  
Physician Negative  
Actions Reporting  
Requirements**

The Medical Group/IPA or Single Purpose Entity is required to immediately notify PacifiCare, in writing, of any of the following actions taken by or against a primary care or specialty physician:

- Surrendering, revocation or suspension of a license or current DEA registration;
- Exclusion of provider from any Federal program (i.e., Medicare or Medicaid) for payment of medical services;
- Filing of any report regarding provider in the National Practitioner Data Bank (NPDB), State Licensing or disciplinary agency;
- Change of hospital staff status or hospital clinical privileges, including any restriction or limitations;
- The Medical Group/IPA or Single Purpose Entity reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of the participating provider that affects or could adversely affect the health and safety of the Member.



**Provider Notification Requirements**

**Revised: 08/2005**

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**Provider Notification Requirements****Revised: 08/2005**

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**Provider Notification  
Requirements**

Participating Providers must notify PacifiCare of any changes in individual Provider status. Those changes shall include, but are not limited to:

- Provider termination;
- Changes in practice, billing or demographic information;
- Changes in capacity of the Provider to provide covered services to Eligible Persons;
- Provider additions to an existing PPO contract.

**Notification  
Addresses**

All Provider notifications should be sent to:

**Arizona Providers**

PacifiCare of Arizona  
P.O. Box 52078  
Phoenix, AZ 85072-2078  
Attn: Network Management

**California Providers**

PacifiCare of California  
5757 Plaza Drive  
Mail Stop: CY44-115  
Cypress, CA 90630  
Attn: PPO Provider Services Department

**Colorado Providers:**

PacifiCare of Colorado  
6455 S. Yosemite Street  
Greenwood Village, CO 80111  
Attention: CO 84-313

**Nevada Providers:**

PacifiCare of Nevada PPO Contracting & Services  
700 E. Warm Springs Road, Suite 200  
Mail Stop: NV64-212  
Las Vegas, NV 89119-4323  
Fax: (702) 269-2917

**Notification  
Addresses  
Continued**

**Oregon Providers, Clark & Cowlitz County Providers:**

PacifiCare of Oregon  
5 Centerpointe Drive, Suite 600  
Lake Oswego, OR 97035  
Fax: 866-895-1115  
Attn: Provider Relations

**South West (Oklahoma and Texas Providers):**

PacifiCare Provider Relations  
P.O. Box 400046  
San Antonio, TX 78229  
Fax: 1-800-455-4156 or 1-210-474-5083

**Washington Providers (excluding Clark & Cowlitz Counties):**

PacifiCare of Washington  
7525 SE 24<sup>th</sup> Street, Suite 200  
Mercer Island, WA 98040  
Fax: 866-895-1019  
Attn: Provider Relations

**Provider  
Termination**

The participating Provider may terminate his/her contract by providing PacifiCare prior written notice of termination as specified in the agreement to the applicable address listed above. **The providers must meet all other terms as set forth in the Participating Provider Agreement.**

**Provider  
Responsibilities  
in Provider  
Termination**

Per the terms of the PPO Physician Agreement, Provider shall:

1. Immediately discontinue use of any and all signs, plaques, letterheads, forms or other materials identifying Provider as a Participating Provider and return to PacifiCare all originals and copies of confidential information, as defined in the Agreement, that are in the Provider's possession or control.
2. If the notice of termination is applicable to a specific Plan, Provider shall continue to be fully responsible under the terms of the Agreement for treatment of Covered Persons enrolled under Plans other than the terminated Plan.

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**Section F: Provider Responsibilities in Termination Cont.  
Plan/Payor Responsibilities in Physician Termination**

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**Provider Notification Requirements**

**Revised: 08/2005**

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**Provider  
Responsibilities in  
Provider  
Termination  
Continued**

3. Identify to PacifiCare, in writing, any Covered Persons who are receiving treatment from Provider for an acute condition or serious chronic condition, high-risk pregnancy or pregnancy in the second (2<sup>nd</sup>) or third (3<sup>rd</sup>) trimester at the time of such written notice and on the effective date of termination.
4. Be responsible for notifying Covered Persons identified in item three (3) above of the termination of the agreement.
5. Subject to authorization by PacifiCare and consistent with applicable State and Federal law and the Agreement:
  - Provider shall remain liable for the provision of, and entitled to payment for, Covered Services furnished subsequent to the termination date to Covered Persons. Covered Persons are those persons who are receiving care or undergoing a course of treatment from Provider at the time of termination until the completion of the care or course of treatment and shall be compensated at the rates described in the Agreement.

**Plan/Payor  
Responsibilities in  
Physician  
Termination**

In the event of notice of termination of the Agreement and upon actual termination of the Agreement, Payor or PacifiCare on behalf of Payor may direct Covered Persons to other Participating Providers.

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## Section F: Provider Notification Requirements for Changes/Terms

### Provider Notification Requirements

Revised: 08/2005

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#### Provider Notification Requirements for Demographic Changes & Terminations

In order to ensure timely communication and claims payment, as well as accurate PPO directory information, Participating Providers must keep PacifiCare informed of any changes to their practice, billing or demographic information. Notifications of such changes and supporting documents must be made as outlined below and sent to the appropriate PacifiCare notification address:

| Type of Change                          | Supporting Documentation Required   |
|---|---|
| Phone/Fax Number                        | <ul style="list-style-type: none"><li>Accepted verbally</li></ul>   |
| Physical Address                        | <ul style="list-style-type: none"><li>Written request with new physical location and effective date</li></ul>   |
| Billing Address                         | <ul style="list-style-type: none"><li>Written request with new billing address and effective date</li><li>Completed W-9 Form</li><li>Sample CMS or UB Form with boxes 31 &amp; 33 completed</li></ul>   |
| Billing Name                            | <ul style="list-style-type: none"><li>Written request with new billing name and effective date</li><li>Completed W-9 Form</li></ul>   |
| Tax ID                                  | <ul style="list-style-type: none"><li>Written request with effective date</li><li>Completed W-9 Form</li></ul>  |
| Termination                             | <ul style="list-style-type: none"><li>Written request with the effective date and the appropriate notice requirements outlined in the Provider Service Agreement</li></ul>  |
| Panel Status Request                    | <ul style="list-style-type: none"><li>Written request with the appropriate notice requirements outlined in the Provider Service Agreement</li></ul>   |
| Age Restrictions                        | <ul style="list-style-type: none"><li>Written request with age restrictions</li></ul>   |
| Provider Name Change (marriage/divorce) | <ul style="list-style-type: none"><li>New medical license</li><li>Completed W-9 Form</li><li>Written request with new name</li></ul>  |
| License or DEA Change                   | <ul style="list-style-type: none"><li>Send copy of updated license or DEA certificate</li></ul>   |
| Hospital Privileges                     | <ul style="list-style-type: none"><li>Written request with hospital name and type of privilege</li></ul>  |
| Specialty Change                        | <ul style="list-style-type: none"><li>Written request with specialty change and appropriate credentials for the requested specialty</li></ul> <p><i>Note: This type of change must go through PacifiCare's credentialing process for approval prior to processing</i></p> |

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**Provider Notification Requirements****Revised: 08/2005**

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**Provider Additions to Existing PPO Contracts**

It is critical that notification of individual Provider additions to existing PPO contracts be forwarded to PacifiCare in a timely manner. Providers not currently credentialed must be credentialed by PacifiCare or the delegated medical group before they may be added to the PPO panel. The credentialing process may take up to ninety (90) days from receipt of the completed credentialing application. Additional information on credentialing can be found in Section E of this Manual.

If Provider is part of a group not delegated for credentialing, notification to add a Provider to an existing PPO contract may be accomplished in one of two ways:

1. Contact PacifiCare at the applicable notification address listed above, indicating desire to add a Provider to an existing PPO contract. If the Provider to be added is not currently credentialed with PacifiCare, PacifiCare will send the Provider a credentialing application.
2. Complete a standard state credentialing application and include a cover letter indicating the desire to add the Provider to an existing PPO contract and send to PacifiCare at the applicable notification address listed above. A W-9 form and a sample CMS or UB form with boxes 31 and 33 completed must be submitted with the credentialing application.

The standard state credentialing application may be accessed on-line for Oregon and Washington.

**Oregon Application:**

- <http://egov.oregon.gov/DAS/OHPPR/ACPCO/docs/FullCredAppABC.doc>

**Washington Application:**

- <http://www.wamss.org>
- Click on “Tools”
- The Provider must print all three (3) forms:
  - Washington Practitioner Application (WPA)
  - Attestation
  - Release

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**Section F: Provider Additions to Existing PPO Contracts Cont.  
Provider Adds to Groups Delegated for Credentialing  
Notification of Actions Against the Provider**

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**Provider Notification Requirements**

**Revised: 08/2005**

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**Provider Additions to Existing PPO Contracts Continued**

**Nevada Application:**

- PPO providers contracted through Nevada Preferred Professionals (NPP) must contact NPP for a credentialing application.

**Texas Application:**

- <http://www.tdi.state.tx.us/company/hmoqual/crform.html>

When credentialing has been approved, PacifiCare will send a letter notifying the Provider of the effective date of his/her participation in the PPO panel.

**Provider Adds to Groups Delegated for Credentialing**

If a Provider is part of a group which is delegated for credentialing, notification of desire to add a Provider to an existing PPO contract should be sent to that medical group. The group will credential the Provider and then send a Provider profile with all data elements outlined in the Credentialing Letter of Agreement and also include a completed W-9 form and a sample CMS or UB form with boxes 31 and 33 completed to the PacifiCare Provider Relations Representative.

**Notifications of Actions Against the Provider**

Provider must immediately notify PacifiCare of any legal, ethics or other actions against the Provider or Provider Representatives or his/her license. Such actions include, but are not limited to, actions by the applicable State regulatory board, professional associations or hospitals. Notification of such actions must be in writing and sent to the appropriate PacifiCare notification address listed above.

**Appeals & Grievances**

**Revised: 06/2005**

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**Appeals**

A covered person, a covered person’s authorized representative or a covered person’s Provider (an “Appellant”) may ask PacifiCare to review any adverse determination (an “appeal”).

**Authorized  
Representatives**

PacifiCare requires the covered person to sign a specific authorization for any person to represent them in an appeal. This requirement is to ensure protection of the covered person’s private health information. A Provider is automatically considered the authorized representative for expedited appeals, but requires documentation from the covered person to represent the covered person on a standard appeal.

*Texas exception: a Texas provider may request an appeal of a pre-service or concurrent denial based on medical necessity without being appointed to represent the covered person.*

**Initiation of an  
Appeal**

An Appellant may initiate an appeal orally or in writing. If the request is oral, PacifiCare will provide the Appellant with an appeal form to complete and return.

PacifiCare will provide an Appellant with an acknowledgement of receiving an appeal.

**Appeal Timeframes**

**Expedited Appeals**

When a covered person’s participation in an appeal over a standard time period is likely to create a serious threat to the covered person’s life or health, an Appellant may request an appeal on an expedited timeframe.

**Standard Appeals**

A standard timeframe is available for any appeal.

**Internal Levels of Appeal**

When an Appellant initiates an appeal, an appropriately qualified PacifiCare reviewer will review the adverse decision at issue, determine how the decision was made and provide the Appellant with a letter setting forth the contractual and/or clinical basis for its decision. If information provided suggests that the original decision was inappropriate, the decision will be reversed, as appropriate, a letter of explanation for the decision reversal will be sent, and the claim or authorization will be reprocessed.

**Additional Levels**

There may be additional levels of appeal available if mandated by state law or if PacifiCare has agreed to offer additional levels of review.

**External Review**

When an adverse decision is made regarding medical necessity of a service or treatment, the Appellant may have a right to an external review after participating, as required, in PacifiCare's internal review process.

**ERISA Notice**

A covered person or the covered person's plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

**Final Dispute Resolution Alternatives**

If, after participating in all legally required review levels, all or any part of the adverse decision is upheld, the parties, on mutual agreement, may submit any unresolved appeal issues to binding arbitration. The arbitration will be held pursuant to the JAMS rules. In the alternative, a covered person always has the right to bring a civil action, as appropriate, under State or Federal law.

**Provider Responsibilities**

The Provider will assist, as requested by PacifiCare, in processing insured grievances and appeals, consistent with the appeals and grievances procedures.

**Billing & Compensation****Revised: 06/2005**

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**Billing &  
Compensation**

A provider may collect any applicable copayments, deductible amounts, coinsurance and payments for services that are not covered by the benefit plan. Copayments should be collected at the time services are rendered. Deductibles, coinsurance and non-covered service amounts should not be collected until a claim has been submitted to PacifiCare or appropriate payor and the claim has been processed.

PacifiCare will pay benefits for covered services that the insured person incurs when the covered expenses exceed the calendar year deductible which may apply. Benefits will be paid at the percentage payable rate set forth in the schedule of benefits. Benefits will not exceed the maximum or limits. Benefits are subject to exclusions and limitations.

**Claims Submission  
Requirements**

PacifiCare reviews and evaluates all service benefit payment submissions for medical necessity and the possibility of billing irregularities. The review relies on and complies with the American Medical Association guidelines and the CPT system coding standards. PacifiCare may adjust or decline benefit payments consistent with the evaluation findings.

PacifiCare shall not be obligated to pay any benefits for any claims if the proof of loss for such claim was not submitted within the period provided, unless it is shown that:

- It was not reasonably possible to have submitted the proof of loss within such period;
- The proof of loss was submitted as soon as it was reasonably possible.

In no event will PacifiCare be obligated to pay benefits for any claim if the proof of loss for such claim is not submitted to PacifiCare within sixty (60) calendar days after the date of loss, except in the case of legal incapacity of the covered person.

**Claims Submission  
Requirements  
Continued**

In accordance with the Provider Agreement, the provider will 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 covered person.

All claims should be submitted to the following address:

**PacifiCare Health Plan Administrators  
Signature Options  
P.O. Box 6099  
Mail Stop CY48-117  
Cypress, CA 90630-6099**

**PacifiCare Health Plan Administrators  
Signature Independence  
P.O. Box 6035  
Mail Stop CY48-117  
Cypress, CA 90630-6035**

**PacifiCare Health Plan Administrators  
Medical/Senior Supplement  
P.O. Box 6072  
Mail Stop CY-48-117  
Cypress, CA 90630-6072**

**PacifiCare Health Plan Administrators  
County of Orange  
P.O. Box 6076  
Mail Stop CY48-117  
Cypress, CA 90630-6076**

**PacifiCare Health Plan Administrators  
PPO Correspondence  
P.O. Box 6098  
Mail Stop CY48-117  
Cypress, CA 90630-6098**

**Self Directed Health Plan (SDHP)  
Signature Freedom  
PacifiCare Health Plan Administrators/Synertech  
P.O. Box 69312  
Harrisburg, Pennsylvania 17106-9312**

**Claims Submission  
Requirements  
Continued**

The following information should be included on the claim:

- Patient's name
- Patient's date of birth and address
- Covered person's name
- Covered person's ID number
- Covered person's employer name and group policy/plan number
- Other insurance and/or responsible third party information, if applicable
- Assignment of Benefits (Signature or indicate "Assignment on File")
- Current CPT and HCPCS coding and applicable modifiers
- Current ICD-9 coding
- Place of service

PacifiCare follows current regulatory payment guidelines which require that all facility charges be submitted on UB-92 claim forms. All charges for professional components, as required by regulations, must be submitted on a CMS 1500 claim form.

Completed superbills and the use of the PacifiCare Medical Claim Form are also accepted, as long as all billing information is included. Balance forward statements will be returned for itemization of charges.

**Claim Timely Filing  
Limit**

The claim's initial timely filing limit is ninety (90) calendar days or as defined in the Provider Agreement. The physician office 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.

**W-9 Requirements**

To ensure proper 1099 reporting, the provider is required to submit any provider changes to PacifiCare at the following address:

**PacifiCare Provider Contracting & Services  
P.O. Box 6006  
Mail Stop CY48-117  
Cypress, CA 90630-6006**

**Fax: 714-226-8513**

**Nevada Providers**

**PacifiCare PPO Contracting & Services  
700 E. Warm Springs Road, Ste. 200  
Mail Stop NV64-212  
Las Vegas, NV 89119**

**Fax: 702-269-2917**

Changes may include changes to the provider billing name (DBA), Tax Identification Number (TIN), billing/practice address and phone number.

**Reimbursement**

Payments for services will be made based on current CPT codes. PacifiCare's Fee Schedule utilizes the Medicare Resource-Based Relative Value System (RBRVS) units for most services and the American Society of Anesthesiologists (ASA) units for anesthesia services.

For services payable at billed charges, PacifiCare reserves the right to review all items for appropriateness. For charges deemed excessive, PacifiCare will adjust payment and reimburse provider at the revised allowable.

Benefits for incurred medical expenses that are covered by PacifiCare will be paid upon receipt of a proper claim by PacifiCare.

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**Section H:****Reimbursement for Professional Components  
Excluded from Professional Component Reimbursement  
Adjudication**

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**Billing & Compensation****Revised: 06/2005**

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**Reimbursement for Professional Components**

Payments for the professional component of services are payable when a provider has supplied a specific professional service to the covered person.

Example: A professional fee would be appropriate when a hands-on procedure, resulting in a detailed report requiring medical interpretation and judgment, is provided.

It is not appropriate for the provider to bill a professional component fee in addition to testing charges unless the provider has provided a direct service to the covered person.

**Excluded from Professional Component Reimbursement**

A professional fee may not be billed for a computer generated report.

Example: The pathology fees paid for a computerized testing contain payment for administrative, overhead and oversight of the tests performed for or by the pathologist, including the maintenance, calibration and oversight of computerized testing equipment.

**Adjudication**

PacifiCare utilizes industry standard claims adjudication and/or clinical practices, State and Federal guidelines, and/or PacifiCare policies, procedures and data to determine appropriate criteria for payment of claims. Their sources include, but are not limited to:

1. Member Eligibility/Data;
2. Established Member Evidence of Coverage to determine covered services;
3. Established Clinical Review Sources (to include Milliman Care Guidelines) to determine medical necessity and Length of Stay (LOS);
4. Established Federal Food and Drug Administration definition for the determination of designated implantable surgical devices and/or implantable orthopedic devices.

**Recoupment**

When an overpayment is made, PacifiCare will send a letter to the provider requesting a refund within thirty (30) working days. If the provider disagrees with the request, the Provider must submit, in writing, the dispute to the following location:

**PacifiCare  
Indemnity Service Center  
P.O. Box 6098  
Mail Stop CY48-117  
Cypress, CA 90630-6098**

**Reciprocity**

The provider will cooperate with PacifiCare's participating providers and other PacifiCare-affiliated entities, and agrees to provide services to insureds in the plans and programs of PacifiCare affiliates and to assure reciprocity of provider healthcare services.

**Coding**

PacifiCare reserves the right to review claims for appropriateness in accordance with prevailing CMS Correct Coding Initiatives (CCI) Edits and adjust payment and reimburse the provider at the revised allowable. The provider shall cooperate with PacifiCare's audits of claims and payments by providing access to requested claims information, all supporting documentation and other related data.

The Revenue and or DRG, ICD-9 and CPT-4 codes listed in the Contract Exhibits are PacifiCare's representations of the coding in place at the commencement of this Agreement for the types of Services contracted under this Agreement. Such codes are subject to changes or additions as updates are made by the issuing entity. PacifiCare participating providers will be expected to utilize industry standards for billing, which include date of service. Both parties will coordinate their efforts in good faith to ensure that relevant and current billing codes are utilized.

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**Provider  
Dispute  
Resolution  
(PDR)**

PacifiCare's Provider Dispute Resolution (PDR) procedure is available to provide a fair, fast and cost-effective resolution of provider disputes in accordance with State and Federal regulations.

PacifiCare's Provider Dispute Resolution procedure is **not** intended to provide a mechanism for renegotiating the terms of a 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 claim disputes. The following guidelines apply to all provider disputes submitted for review:

**Timely  
Filing of  
Disputes**

All disputes must be submitted within one hundred eighty (180) calendar days following the date of the first level determination, unless State law precludes this.

PacifiCare reserves the right to deny/reject any request for review that is submitted beyond the one hundred eighty (180) day timely filing deadline, unless State law precludes this.

**Provider  
Acting on  
Behalf of the  
Member in  
an Appeal**

The Provider Dispute Resolution process is separate and distinct from the PacifiCare Member Appeals and Grievances procedure. A provider may assist a PacifiCare Member in submitting a Member appeal or grievance for resolution or submit the appeal on behalf of the Member; however, a contracted provider cannot directly appeal a decision under the PacifiCare Member Appeals and Grievances procedure. (Note: Providers wishing to appeal on behalf of a Member must obtain a written authorization to represent the Member.)

**Provider  
Dispute  
Resolution  
Continued****Submitting  
Disputes**

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

- Clear rationale or reason for contesting the determination;
- Provider contact information;
- 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 and supporting documentation needed to review the provider's dispute (i.e., claims, medical records, authorizations, etc.).

**Where to  
Submit  
Provider  
Disputes**

The provider must submit dispute requests to:

PacifiCare PPO Provider Dispute Resolution  
P.O. Box 6098  
Cypress, CA 90630-6098

**Processing  
a Dispute**

Upon receipt of a dispute, PacifiCare will:

- Determine if all the information is present to process the provider dispute. Incomplete disputes will be returned to the provider within thirty (30) working days from the date of receipt. Providers must submit the additional information within thirty (30) working days or give up their right to dispute the issue;
- Conduct a thorough review of the provider's request and all supporting documentation;
- Supply the provider with a written determination within forty-five (45) working days of receipt.

**Provider  
Dispute  
Resolution  
Continued****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. The provider can submit a Provider Dispute after the Member appeal decision is made. If the provider is appealing on behalf of the Member, the appeal will be processed as a Member appeal;
- An Independent Medical Review (IMR) initiated by a Member through the Member Appeals Process;
- Any dispute filed outside of the one hundred eighty (180) calendar day timely filing limit which fails to supply "good cause" for the delay.

**Arbitration**

If the provider is not satisfied with the formal determination, the provider may submit the dispute within one hundred twenty (120) calendar days of the decision to arbitration in accordance with the terms of the Provider Agreement.

**Duplication of Coverage****Revised: 06/2005**

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**Coordination of Benefits**

Coordination of Benefits (COB) is the practice of two (2) or more plans coordinating their provision of health benefits to insureds who have multiple coverage.

PacifiCare may coordinate benefits with benefits available under other similar health insurance policies. COB between policies may result in a reduction in the amount of benefits ordinarily payable, so that the provider never receives a total, from all Plans, of more than one hundred percent (100%) of covered expenses incurred. All benefits provided are subject to this coordination provision.

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

**Order of Benefit Determination Rules**

General rules regarding COB include the following:

1. The plan without a COB provision pays before one with such provision;
2. The plan which covers a person other than as a dependant pays before a plan which covers a person as a dependant;
3. For a covered dependant child, the plan of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year pays before the plan of the parent whose date of birth, excluding year of birth, occurs later in a calendar year. To apply, the coordinating plan must have a similar provision;
4. If two (2) or more plans cover a dependant child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the plan of the parent with custody of the child,
  - Then, the plan of the spouse of the parent with custody of the child,
  - Next the plan of the non-custodial parent,
  - Finally, the plan of the spouse of the non-custodial parent pays last.

However, where court decree orders one parent responsible for the healthcare expenses of the child, the plan of that parent pays first;

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**Duplication of Coverage****Revised: 06/2005**

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**Order of Benefit  
Determination Rules  
Continued**

5. When rules 1 through 4 do not establish the order of benefit determination, the plan covering the person for a longer period pays first; however:
- The plan covering the person as a laid-off employee, or as a dependant of a laid-off or retired employee, will pay after any other plan covering that person as a full-time employee, or dependant of a full-time employee;
  - If the other plan does not have an order of benefit determination rule regarding laid-off or retired employees, then the provision of the above rule will not apply.

**Secondary Payor  
Policy**

When it is determined that PacifiCare is the secondary carrier, PacifiCare will coordinate available benefits in an attempt to make the Member whole by considering the Member's Out of Pocket Expense after the primary carrier's payment.

Model COB provider contract language is used to calculate Allowable Expense and limits PacifiCare's liability when secondary.

**Release of  
Information**

For determining the applicability and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, PacifiCare may release or obtain from any insurance company or other organization or person any information, with respect to any covered person, which the plan deems to be necessary for such purposes. Any covered person claiming benefits must furnish information necessary to implement this provision.

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**Duplication of Coverage****Revised: 06/2005**

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**Right of Recovery**

Whenever payments for covered expenses exceed the maximum payment necessary to satisfy COB provisions, PacifiCare may recover such excess payments. The term "payments for covered expenses" includes the reasonable cash value of any benefits provided in the form of services.

**CHAMPUS/  
TRICARE**

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

The covered person shall furnish, upon request from PacifiCare, information concerning any applicable benefits from CHAMPUS/TRICARE which the covered person may be entitled to receive. PacifiCare shall not furnish benefits under the policy which duplicate the benefits to which the covered person is entitled under CHAMPUS/TRICARE.

If payment is made by PacifiCare in duplication of the benefits available under CHAMPUS/TRICARE, PacifiCare may seek reimbursement up to the amount of benefits which duplicate such benefits under CHAMPUS/TRICARE.

**Workers'  
Compensation**

Workers' Compensation has primary responsibility for payment in all compensatory work-related injuries or illnesses. PacifiCare will not furnish benefits to any insured which duplicate the benefits to which an insured 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.

**Workers'  
Compensation  
Continued**

In the event of a dispute regarding the covered person's receipt of benefits under Workers' Compensation laws, PacifiCare will provide the benefits described in the policy until resolution of the dispute.

In the event PacifiCare provides benefits which duplicate the benefits the covered person is entitled to under Workers' Compensation law, the covered person agrees to reimburse PacifiCare, for all such benefits provided by PacifiCare, immediately upon obtaining any monetary recovery. The covered person shall hold any sum collected that is the result of a Workers' Compensation action in trust for PacifiCare. Such sum shall equal the lesser of the amount of the recovery obtained by the covered person or the benefits furnished to the covered person by PacifiCare on account of each incident.

The covered person agrees to cooperate in protecting the interests of PacifiCare under this provision. The covered person must execute and deliver to PacifiCare any and all liens, assignments or other documents necessary to fully protect the right of PacifiCare, including, but not limited to, the granting of a lien right in any claims or action made or filed on behalf of the covered person.

**Medicare Benefits**

PacifiCare shall not furnish benefits which duplicate the benefits the covered person is entitled to as a Medicare beneficiary. Should the cost of medical or hospital services exceed Medicare coverage, PacifiCare benefits shall be provided over and above such coverage.

If payment is made by PacifiCare in duplication of the benefits available to the covered person as a Medicare beneficiary, PacifiCare may seek reimbursement from the insurance carrier, provider or covered person up to the amount of benefits which duplicate Medicare benefits.

In the following instances, PacifiCare will provide benefits to covered persons with Medicare coverage, and Medicare will be responsible for payment only to the extent of services not covered under the policy:

**Duplication of Coverage****Revised: 06/2005**

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**Medicare Benefits  
Continued**

1. Aged employees: Insured persons who are actively at work and are age sixty-five (65) or older, or any dependant age sixty-five (65) or older, and are enrolled through an employer group that has twenty (20) or more employees;
2. Disabled employees (larger employer): covered persons eligible for Medicare as a result of a disability if covered persons are enrolled through an employer that has one hundred (100) or more full-time employees; and
3. End-Stage Renal Disease (ESRD) Beneficiaries (initial period): The covered Person entitled to Medicare solely on the basis of ESRD for a maximum of thirty (30) months, beginning the earlier of:
  - a) the month in which the covered person initiates a regular course of renal dialysis; or
  - b) the month in which an individual who receives a kidney transplant could become entitled to Medicare.

In the following instances, PacifiCare's coverage will be limited to the cost of covered services not covered by Medicare:

1. Covered persons who meet the following definition of Medicare retiree: a covered person who is:
  - a) eligible for Medicare Part A and/or Part B (whether or not enrollment in Medicare actually occurs),
  - b) eligible for retiree coverage provided by the group policyholder, and
  - c) properly enrolled under the policy;
2. Small group employees: covered persons enrolled through an employer with fewer than twenty (20) full-time employees;
3. Disabled employee (small groups): Covered persons eligible for Medicare as a result of disability, who are enrolled through an employer with fewer than one hundred (100) full-time employees;
4. End-Stage Renal Disease (ESRD) Beneficiaries (Subsequent Period): Covered persons entitled to Medicare as a result of ESRD who do not meet the requirements of PacifiCare's primary insurance requirements.

**Automobile, Accident  
or Liability Coverage**

PacifiCare shall not furnish benefits which duplicate benefits the covered person is entitled to under any automobile, accident or liability coverage. The covered person is responsible for taking whatever action necessary to obtain the available benefits of such coverage and will notify PacifiCare of receipt of such available benefits. If payment is provided by PacifiCare in duplication of the benefits under other automobile, accident or liability coverage, PacifiCare may seek reimbursement for the duplicate benefits.

**Third Party Liability  
(TPL)**

If an insured is entitled to payment from a third party (excluding a Workers' Compensation carrier or primary insurance carrier under applicable COB rules), the provider, as documented in the Provider Services Agreement, is responsible for any claims or demands against the third party for amounts due for services.

Third party liability applies as follows:

- A covered person suffers an injury or sickness through the act or omission of another person; and
- Benefits are paid under the policy for that injury or sickness.

PacifiCare is entitled to a refund of all compensatory benefits paid. The refund must equal the payment for the injury or sickness by the third party. PacifiCare may file a lien against the third party payment. The Covered Person must complete and return any required forms to PacifiCare upon request.

The covered person agrees that PacifiCare's rights to reimbursement for compensatory benefits under the COB are the first priority claim against any third party. PacifiCare shall be reimbursed from any recovery of compensatory claims before payment or any other existing claims, including any claims by the covered person for general damages. PacifiCare may collect from the proceeds of any settlement or judgment recovered by the covered person or his/her legal representative, regardless of whether the covered person is fully compensated. Punitive damages are not calculated under the policy.

**Duplication of Coverage****Revised: 06/2005**

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**Third Party Liability  
(TPL) Continued**

The covered person agrees to cooperate in protecting the interests of PacifiCare. The covered person must execute and deliver to PacifiCare any and all liens, assignments or other documents necessary to fully protect the right of PacifiCare, including, but not limited to, the granting of a lien right in any claim or action made or filed on behalf of the covered person. The covered person's failure to cooperate with PacifiCare may result in such covered person's termination under the policy.

The covered person shall not settle any claim or release any person from liability without the written consent of PacifiCare, if such release or settlement extinguishes or bars PacifiCare's rights of reimbursement.

In the event PacifiCare employs an attorney for the purpose of enforcing any part of this against a covered person, based on the covered person's failure to cooperate with PacifiCare, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees.

In lieu of payment as indicated, PacifiCare, at its option, may choose to be subrogated to the covered person's rights to the extent of the benefits received under the policy. PacifiCare's subrogation right shall include the right to bring suit in the covered person's name. The covered person shall fully cooperate with PacifiCare when PacifiCare exercises its right of subrogation and the covered person shall not take any action or refuse to take any action which should prejudice the right of PacifiCare.

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**Pharmacy Control Program****Revised: 06/2005**

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**Formulary**

PacifiCare's formulary includes most generic drugs and a broad selection of brand name drugs. Prescription drugs listed on the formulary are considered a covered benefit. The formulary can be accessed via any of the following:

1. Providers can fax requests for hardbound copies, wall charts or alternative lists to PacifiCare's PPO/SDHP pharmacy at 206-230-7487;
2. Web site access is open to covered persons and Providers at [www.pacificare.com](http://www.pacificare.com):
  - Once the state is selected, click on "library" and then select the "pharmacy" tab;
  - Select PPO/SDHP formulary;
3. Providers can use a fax on demand service which provides immediate access to formularies, pre-authorization guidelines and after-hours procedures. Documents may be ordered by calling 1-877-MDRxFAX from any touch-tone phone. Document #1000 is a catalog of all available documents.

Provider requests for formulary review of medications or guidelines are welcome. Contact PacifiCare's Pharmacy department or submit requests on-line at [www.rxsolutions.com](http://www.rxsolutions.com). Select "Healthcare Professionals" and then the "Provider Feedback Forms" link.

**Managed  
Care  
Formulary  
Plans**

PacifiCare offers a Managed Care Formulary Plan to employer groups. In this plan, the Prior Authorization process applies to all non-formulary medications. Additionally, coverage for selected formulary drugs may require prior authorization to ensure that the selected drugs are medically necessary and are utilized according to treatment guidelines consistent with professional practice. Any prescription for a non-formulary drug or for a formulary drug that requires prior authorization is the covered person's financial responsibility, unless the covered person meets the criteria for coverage under the prior authorization process.

**Open and Buy-Up/Three Tier Plans**

PacifiCare also offers Open Formulary and Buy-up Plans to employer groups. Through these plans, non-formulary medications are generally covered at a higher copayment, without pre-authorization. However, coverage for selected drugs will require pre-authorization to ensure that the selected drugs are medically necessary and are being utilized according to treatment guidelines consistent with good professional practice. Medications which require pre-authorization are designated on the on-line version of the formulary at [www.pacificare.com](http://www.pacificare.com).

**Non-Covered Medications**

“Non-Covered” medications are generally excluded from coverage in accordance with the covered person’s benefit design and may vary by plan design. Examples may include:

- Anorexiants or other weight loss medications;
- Agents for cosmetic purposes (e.g., treatment for wrinkles, discolored nails, hair growth);
- Injectable agents, with the exception of insulin and other agents, as outlined in the plan design. These are covered under the covered person's medical benefit and subject to any applicable coinsurance and deductible;
- Prescription medications with an over-the-counter equivalent;
- Branded medications when generic equivalents are available, unless the covered person’s plan allows covered person to pay applicable copay, plus cost difference;
- Investigational medications;
- Sexual dysfunction agents.

**Prescriber Request for Pre-Authorization**

PacifiCare has a “pre-authorization” or exceptions process in place to ensure that medications are prescribed safely and effectively for our Members.

The Pre-Authorization staff will adhere to plan-approved criteria, National Pharmacy and Therapeutics (NPTC) practice guidelines and other professionally recognized standards in reviewing each case. A decision will be rendered based on established protocols and guidelines and referring cases to clinical pharmacists in accordance with standing procedures.

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**Section K: Prescriber Request for Pre-Authorization Cont.****Pharmacy Control Program****Revised: 06/2005**

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**Prescriber  
Request for Pre-  
Authorization  
Continued**

The request for a drug which requires pre-authorization may only be made by the physician or a designated employee or individual under the direction and control of the physician, and who is located in the physician's office or other site where the covered person is receiving medical services.

The pre-authorization functions may not be delegated to a third party who is not located at the physician's office or other site where the covered person is receiving medical services. Clinical pharmacists who work in a utilization management capacity within a medical group and who are directly employed by or contracted with that medical group may also make requests. Prescribers or their designated agents requesting authorization can do so:

- Through a toll-free number (1-800-711-4555);
- By written request via fax (1-800-527-0531). Prescribers can obtain a Pre-Authorization Medication Request Form by calling MDRxFax (877) 637-9329 and requesting Document 1300;
- Through the Internet at [www.rxsolutions.com](http://www.rxsolutions.com), under the "Healthcare Professionals" icon. If using the Internet, enter patient and physician information, select "add medication" and complete required fields. You will be contacted by Prescription Solutions to validate your request.

The pre-authorization request must include specific information related to the covered person's medical condition and course of treatment, as requested by Prescription Solutions.

Prescription Solutions' prior authorization staff will not process the request until all necessary information is received from the physician. Prescription Solutions will communicate with the physician, or designated employee or other individual under the direction and control of the physician, regarding whether or not the non-formulary drug will be covered. Prescription Solutions' determination will be made within forty-eight (48) hours of receipt of all the necessary information requested.

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**Section K: Prescriber Request for Pre-Authorization Cont.****Pharmacy Control Program****Revised: 06/2005**

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**Prescriber  
Request for Pre-  
Authorization  
Continued**

The following information is required to evaluate each case prior to issuance of an authorization:

- Covered person's name
- Covered person's ID#
- Covered person's date of birth
- Covered person's gender
- Prescriber name
- Prescriber specialty
- Prescriber address
- Prescriber phone/fax number
- Name and dosage strength of the requested medication
- Directions for use
- Diagnosis
- Date patient started on the non-formulary medication
- Name of specific drugs tried and failed
- Pertinent lab results (i.e., lipid panels, BMD scores, MMSE results)
- Documentation of patient chart notes in accordance with the specifications outlined in the NPTC Guidelines or, where appropriate, as the community standard of practice

A written communication of case resolution is faxed to the Provider for each case serviced.

Denial determinations require a letter to be sent to both covered person and prescriber stating the reason why the medication is being denied and outlining the process for filing standard and expedited appeals

|                                  |                                   |   |
|----------------------------------|-----------------------------------|---|
| <b>Prescription Drug Benefit</b> | <b>Medication Coverage</b>        | <p>The following medications are covered when prescribed by a participating primary care physician or referral specialist and filled at a PacifiCare participating pharmacy:</p> <ul style="list-style-type: none"><li>• Any medicinal substance, which by State or Federal law may be dispensed only by prescription, unless otherwise excluded;</li><li>• Insulin and insulin syringes, blood glucose test strips, lancets, inhaler extender devices, anaphylaxis prevention kits;</li><li>• Federal legend oral contraceptives, prescription diaphragms;</li><li>• Generic Drugs: Comparable generic drugs will be substituted for brand-name drugs;</li><li>• Specified smoking cessation products when a covered person meets nicotine dependency criteria and is enrolled and continues to participate in PacifiCare’s Stop Smoking Program.</li></ul>            |
|                                  | <b>Exclusions and Limitations</b> | <p>While the prescription drug benefit covers most medications, there are some that are not covered or are limited to:</p> <ul style="list-style-type: none"><li>• Drugs or medicines not on the PacifiCare Formulary, unless pre-authorized by PacifiCare;</li><li>• Drugs or medicines purchased and received prior to the covered person’s effective date or subsequent to the covered person’s termination;</li><li>• Therapeutic devices or appliances, including, but not limited to, hypodermic needles, syringes (except insulin syringes) not related to diabetic needs or cartridges, support garments and other non-medicinal substances and insulin pumps and related supplies (these services are provided as durable medical equipment);</li><li>• All non-prescription (over-the-counter) contraceptive jellies, ointments, foams and devices;</li></ul> |

**Pharmacy Control Program****Revised: 06/2005**

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**Prescription  
Drug  
Benefit  
Continued****Exclusions  
and  
Limitations  
Continued**

- Oral vaccines;
- Medications administered to a covered person while an inpatient in a hospital or while receiving skilled nursing care as an inpatient in a skilled nursing facility. Outpatient prescription drugs are covered for covered persons receiving custodial care in a rest home, nursing home, sanitarium or similar facility if they are obtained from a participating pharmacy;
- Drugs or medicines delivered or administered to the covered person by the prescriber or the prescriber's staff. Injectable drugs are covered under the medical benefit;
- Dietary or nutritional products and food supplements, whether prescription or non-prescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine. PKU treatment is covered under the medical benefit;
- Elective or voluntary enhancement procedures, services, supplies and medications, including, but not limited to:
  - weight loss
  - hair growth
  - sexual performance
  - athletic performance
  - cosmetic purposes
  - anti-aging for cosmetic purposes
  - mental performance

Examples of these drugs include, but are not limited to:

- Penlac®
- Retin-A®
- Renova®
- Vaniqa®
- Propecia®
- Lustra®
- Xenical®
- Meredia®

Anorexiants/anti-obesity medications may be reviewed by Prior Authorization for the treatment of morbid obesity;

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**Pharmacy Control Program****Revised: 06/2005**

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**Prescription  
Drug Benefit  
Continued****Exclusions  
and  
Limitations  
Continued**

- All homeopathic medications;
- Glucagon diagnostic kit;
- Preven – emergency contraceptive kit;
- Compound medications are not covered unless pre-authorized as medically necessary by PacifiCare;
- All forms of prescription medication when prescribed for the treatment of infertility. These may be covered under a supplemental benefit;
- Smoking cessation products (other than those available by participating in PacifiCare's StopSmoking<sup>SM</sup> Program) including, but not limited to:
  - nicotine gum
  - nicotine patches
  - nicotine nasal spray;
- Injectable drugs including, but not limited to:
  - self-injectables
  - infusion therapy
  - allergy serum
  - immunization agents
  - blood products;

These are covered under the medical benefit portion of a covered person's plan.
- Drugs prescribed by a dentist or drugs used for dental treatment;
- Drugs used for diagnostic purposes;
- New medications that have not been reviewed for safety, efficacy and cost-effectiveness and approved by PacifiCare, unless pre-authorized by PacifiCare as medically necessary;
- Prescription medications for the treatment of a non-covered medical condition. This exclusion does not exclude medically necessary medications directly related to non-covered services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery;

**Prescription  
Drug Benefit  
Continued****Exclusions  
and  
Limitations  
Continued**

- Saline and irrigation solutions. Saline and irrigation solutions are covered when medically necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit;
- All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence, anorgasmia or hyporgasmia;
- Drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease law or any State or government agency, or drug furnished by any other drug or medical service for which no charge is made to the patient;
- Replacement of lost, stolen or destroyed medications;
- Medication prescribed for experimental or investigational therapies, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4;
- Off-label drug use. Off-label drug use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. PacifiCare excludes coverage for off-label drug use, including off-label self-injectable drugs, except as described in the Subscriber Agreement and any applicable Attachments. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria:
  1. The drug is approved by the FDA;
  2. The drug is prescribed by a participating, licensed health care professional;

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**Pharmacy Control Program****Revised: 06/2005**

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**Prescription  
Drug Benefit  
Continued****Exclusions  
and  
Limitations  
Continued**

3. The drug is medically necessary to treat the condition;
4. The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following sources:
  - The American Medical Association Drug Evaluations;
  - The American Hospital Formulary Service Drug Information;
  - The United States Pharmacopoeia Dispensing Information; or
  - In two articles from major peer-reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective.

Nothing in this section shall prohibit PacifiCare from use of a formulary, copayment, technology assessment panel or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the covered person to use the Independent Medical Review System as defined in the medical Combined Evidence of Coverage and Disclosure Form.

PacifiCare reserves the right to expand the prior authorization requirement for any drug product to assure adherence to FDA-approved indications and national practice standards.

**Pharmacy  
Network**

Covered persons can receive prescriptions from any contracted network pharmacy. PacifiCare is contracted with a nationwide network of pharmacies. Contracted pharmacies and locations are available on-line at [www.pacificare.com](http://www.pacificare.com).

**Mail Service**

All PacifiCare Members with a prescription drug benefit are eligible to use our prescription mail service.

Prescriptions for mail service should be written for a three (3) month (ninety (90)-day) supply and up to three (3) additional refills, when appropriate. Only medications that are taken for chronic conditions should be ordered through the mail. Acute prescription needs such as antibiotics and pain medications should be obtained through a network pharmacy site to avoid delay in treatment.

Physicians may also elect to discourage covered persons from using the mail service for medications where large quantities dispensed at one time to the covered person may pose a problem (e.g., tranquilizers or pain medications).

Covered persons can receive a mail service form by calling:

Prescription Solutions Customer Service  
(M-F 5:00 a.m. to 9:00 p.m.; Sat-Sun 7:00 a.m. to 7:00 p.m.)  
(800) 562-6223  
TDHI (800) 498-5428

Or

PacifiCare Customer Service  
(M-F 7:00 a.m. to 9:00 p.m.)  
Phone Numbers  
HMO - (800) 624-8822  
POS - (800) 913-9133  
PPO - (866) 316-9776

**PacifiCare  
Drug  
Utilization  
Review  
Program**

PacifiCare is dedicated to working with our medical providers to supply information and education needed to effectively manage the growing cost of pharmaceutical care. Our clinical pharmacists can identify and analyze areas where physicians may be able to prescribe products that are considered to be effective, as well as economical.

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**Section K: PacifiCare Drug Utilization Review Program Cont.  
Specialty Injectable Program**

**Pharmacy Control Program**

**Revised: 06/2005**

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**PacifiCare  
Drug  
Utilization  
Review  
Program  
Continued**

Additionally, PacifiCare's pharmacy staff can help identify when a more detailed review of therapy may improve patient care, such as:

- Overuse of controlled substances
- Duplicate therapies
- Drug interactions
- Polypharmacy

**Specialty  
Injectable  
Program**

For covered person and Provider convenience, PacifiCare offers a comprehensive Specialty Pharmacy Program to address the needs of covered persons using self-administered or office-based injectable drug products. Medications can be shipped directly to the covered person's home or to the Provider's office, upon request. Compliance and disease state monitoring programs are also available to assist covered persons in getting the most out of their specialty pharmacy care.

These medications are part of the covered person's medical benefit and subject to applicable deductibles, coinsurance and out-of-pocket/coinsurance maximums. Pre-authorization may be required, depending on benefit design.

Medications may be requested via Prescription Solutions Specialty Pharmacy Program at 1-877-455-7171, Option 1, for the injectable team. Copayments or coinsurance will be coordinated directly with the covered person, as well as any special shipping or delivery arrangements.

**ELECTRONIC DATA INTERCHANGE (EDI)****Revised: 11/2005**

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## EDI

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|                           |                            |   |
|---------------------------|----------------------------|---|
| <b>PacifiCare<br/>EDI</b> | <b>EDI<br/>Description</b> | <p>Electronic Data Interchange (EDI) is the exchange of information between trading partners conducted in a standard electronic format. The electronic flow of data between trading partners allows for minimum human intervention and may help reduce costly and time-consuming activities which are sometimes associated with traditional paper and manual transactions. Today, EDI transactions commonly used in the health care industry are: electronic claims and encounters submission, electronic eligibility and benefits verification, electronic claims status inquiry, electronic remittance advice (ERA) and electronic funds transfer (EFT), to name a few.</p>   |
|                           | <b>EDI<br/>Benefits</b>    | <p>EDI transactions can potentially save time and money by streamlining daily office administrative tasks. Some of the many benefits of EDI are:</p> <ul style="list-style-type: none"> <li>• Reduces clerical errors associated with the manual handling of paper transactions;</li> <li>• Enhances data accuracy with error detection through front-end reject reports, which can assist in the timely correction and resubmission of data;</li> <li>• Allows acknowledgement of data submission that can be used as proof of timely filing;</li> <li>• Provides office administrative savings through the reduction of postage and printing costs;</li> <li>• Enhances office workflow and billing cycle, which may have a positive impact on cash flow;</li> <li>• Provides maximum workflow flexibility by allowing transmission of data 24 hours a day, 7 days a week.</li> </ul> |
|                           | <b>HIPAA</b>               | <p>The Health Insurance Portability and Accountability Act (Kennedy-Kassebaum Bill) of 1996, also known as HIPAA, was enacted as part of an effort by the Federal government to reform the health care industry. Included in the Act is a section on Administrative Simplification (HIPAA-AS), which establishes national standards for electronic health care transactions, including national identifiers for providers, health plans and employers. In addition, HIPAA also addresses the privacy and security of health data.</p> <p>One of the goals of HIPAA is to stimulate the growth of EDI usage in the health care industry through administrative efficiencies resulting from the adoption of national transaction standards.</p> <p>Listed below are standardized HIPAA EDI transactions, with versions that PacifiCare accepts:</p>                                       |

## EDI

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| PacifiCare EDI                             | HIPAA EDI Transactions        | ANSI X12 Transactions  | Approved Versions | Descriptions                           |
|--|-------------------------------|--|-------------------|--|
| <b>Continued</b>                           |                               | 837  | 4010X098A1        | Professional Claims & Encounters       |
|  |                               | 837  | 4010X096A1        | Institutional Claims & Encounters      |
|  |                               | 835  | 4010X091A1        | Electronic Remittance Advice (ERA)     |
|  |                               | 834  | 4010X095A1        | Group Enrollment/Disenrollment         |
|  |                               | 278  | 4010X094A1        | Referral Certification & Authorization |
|  |                               | 270/271  | 4010X092A1        | Eligibility Inquiry & Response         |
|  |                               | 276/277  | 4010X093A1        | Claims Status Inquiry & Response       |
|  | <b>Companion Guides</b>       | Please refer to the PacifiCare Companion Guides for detailed information on the required data elements for each transaction. Companion Guides are available for viewing or download from the PacifiCare Provider Portal at <a href="http://www.pacificare.com">www.pacificare.com</a> .  |                   |  |
| <b>Getting Started with PacifiCare EDI</b> | <b>EDI Clearinghouses</b>     | <p>PacifiCare accepts EDI transactions from multiple clearinghouses. With some clearinghouses, you submit data directly from your computer to their secure server. With others, you submit data via the Internet. In both cases, the transmissions are secure and protected. Clearinghouses typically have relationships with many payers, so you could be submitting all your data, not just PacifiCare's data, electronically.</p> <p>You may be required to test with your clearinghouse prior to submitting EDI data to PacifiCare. Upon completion of testing, your clearinghouse will notify you of the date in which you may begin transacting live data with PacifiCare.</p> |                   |  |
|  | <b>List of Clearinghouses</b> | <p>You must first contact your preferred clearinghouse to determine their connectivity to PacifiCare. Listed below are some clearinghouses that have already established connectivity with PacifiCare:</p> <ul style="list-style-type: none"> <li>• Diversified Data Design Corp. (DDD)*<br/>(310) 973-2880<br/><a href="http://www.dddcorp.com">www.dddcorp.com</a></li> <li>• Electronic Network System (ENS)<br/>(800) 341-6141<br/><a href="http://www.enshealth.com">www.enshealth.com</a></li> <li>• Emdeon<br/>(877) 469-3263<br/><a href="http://www.emdeon.com">www.emdeon.com</a></li> </ul>   |                   |  |

### Getting Started with PacifiCare EDI Continued

#### List of Clearinghouses Continued

- Herae\*\*  
(888) 414-3723  
[www.herae.com](http://www.herae.com)
- M Transaction Services  
(866) 802-8899  
[www.mtsedi.com](http://www.mtsedi.com)
- Office Ally  
(949) 464-9129  
[www.officeally.com](http://www.officeally.com)
- ProxyMed  
(800) 586-6870  
[www.proxymed.com](http://www.proxymed.com)
- The SSI Group, Inc. (SSI)  
(800) 881-2739  
[www.ssigroup.com](http://www.ssigroup.com)
- THIN, Inc.  
(972) 766-5480  
[www.thinedi.com](http://www.thinedi.com)

*\*Offers EDI Encounters submission only.*

*\*\*Offers Electronic Remittance Advice (ERA) ANSI X12 835 transaction only.*

#### Payer ID

The Payer ID is an identification number that instructs the clearinghouse where to send your electronic data. You must use the appropriate Payer ID number when submitting your EDI data for PacifiCare. Please refer to **Figure L-1** (*Quick Reference Tool EDI Payer ID Guide*) for a complete listing of the PacifiCare Payer ID number for the applicable products and corresponding markets.

## EDI

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|  |  |   |
|--|--|---|
| <b>PacifiCare<br/>EDI<br/>Transactions</b> | <b>EDI Claims/<br/>Encounters</b>                              | <p>The following are EDI transactions available with PacifiCare:</p> <ul style="list-style-type: none"> <li>• EDI claim is the preferred method of submission for PacifiCare Providers. You may submit all professional and institutional claims and/or encounters for our entire HMO and PPO product lines electronically. The HIPAA ANSI X12 837 format is the only acceptable format for submitting claims/encounters data to PacifiCare. Please refer to the PacifiCare-published Companion Guides for the required data elements.</li> </ul>   |
|  | <b>Electronic<br/>Remittance<br/>Advice (ERA)</b>              | <ul style="list-style-type: none"> <li>• ERA allows a Provider to obtain an electronic version of the PacifiCare Explanation of Payment (EOP). Depending on your system's capability, the data may be uploaded directly to the ledger of your practice computer system. ERA can potentially replace the tedious process of manual EOP reconciliation, posting and data entry. PacifiCare only accepts the HIPAA ANSI X12 835 format for this transaction. Please refer to the PacifiCare-published Companion Guides for the required data elements.</li> </ul>  |
|  | <b>Electronic<br/>Eligibility<br/>Inquiry /<br/>Response</b>   | <ul style="list-style-type: none"> <li>• One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information. This EDI transaction is a powerful productivity tool that allows Providers to instantly obtain covered person's eligibility and benefit information in "real-time," using a computer instead of the phone, prior to scheduling and confirming the patient's appointment. PacifiCare only accepts the HIPAA ANSI X12 270/271 format for this EDI transaction. Please refer to the PacifiCare-published Companion Guides for the required data elements.</li> </ul> |
|  | <b>Electronic<br/>Claims Status<br/>Inquiry /<br/>Response</b> | <ul style="list-style-type: none"> <li>• This EDI transaction allows a Provider to send and receive in "real-time" an electronic status of a previously submitted claim using a computer. Claims with missing or inaccurate information can be resubmitted, which greatly enhances the Provider's receivables and cash flow cycle. PacifiCare will only accept the HIPAA ANSI X12 276/277 format for this EDI transaction. Please refer to the PacifiCare-published Companion Guides for additional information on the required data elements.</li> </ul>   |
|  | <b>Group<br/>Enrollment/<br/>Disenrollment</b>                 | <ul style="list-style-type: none"> <li>• This EDI transaction allows qualified employers to electronically enroll and/or disenroll their employees in a PacifiCare health plan. PacifiCare accepts the HIPAA ANSI X12 834 as one of the acceptable formats for this transaction. Please refer to the PacifiCare-published Companion Guides for additional information on the required data elements.</li> </ul>   |

## EDI

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PacifiCare  
Enterprise  
EDI Services  
(EES)

## Role of EES

The Enterprise EDI Services (EES) Team supports the planning and implementation of PacifiCare's EDI strategy across all PacifiCare markets. Its vision is to enable PacifiCare and its constituents, both internal and external, to conduct business electronically by providing economic, technology and operating capabilities.

## EES Contact

Whether you are a new EDI submitter, or you are already submitting electronically and require technical support, the EES department has a complete staff dedicated to answering and assisting you with all of your EDI questions.

For questions about selecting a clearinghouse, or information on how to get started with PacifiCare EDI:

- Call the PacifiCare EDI Outreach Team at 1-800-203-7729
- Write us at [edioutreach@phs.com](mailto:edioutreach@phs.com)

If you are already using EDI and require assistance and/or technical support:

- Call the PacifiCare EDI Support Team at 1-800-203-7729
- Write us at [edisupport@phs.com](mailto:edisupport@phs.com)

You can also visit us at [www.pacificare.com](http://www.pacificare.com) for more information.

EDI  
ResourcesFrequently  
Asked  
Questions  
(FAQs)

Listed below are helpful tips and answers to common EDI questions:

1. Can I submit my PacifiCare PPO claims electronically?

*Yes, PacifiCare accepts EDI claims submission for all of our PPO product lines. Please refer to page L-2 of this manual, "Getting Started with PacifiCare EDI", for further information.*

2. How do I prevent timely filing denials?

*Submit your claims via EDI and receive your electronic confirmations from the clearinghouse. These acknowledgements will serve as your "proof" of timely submission. It is not necessary to submit the same claim via both EDI and paper.*

## EDI

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EDI  
Resources  
ContinuedFrequently  
Asked  
Questions  
(FAQs)  
Continued

3. Can I send descriptive information for certain electronic claims? For example, procedure codes.

*Claims filed electronically have additional fields to document further narrative information. Please refer to your billing software provider or your clearinghouse for more information.*

4. How do I submit claims with an Explanation of Benefits (EOB) attached?

*The HIPAA 837 transaction provides supplemental fields for EOB-related information. This will require that either your billing software is HIPAA 837 compliant or your clearinghouse can provide this information for you. Please refer to your billing software provider or contact your clearinghouse to determine the feasibility of sending supplemental EOB data with your electronic claims.*

5. How do I resubmit my previously denied claims?

*Claims previously submitted that were either denied or pending additional information **should not be resubmitted as electronic or as new paper claims.** Please contact PacifiCare's Customer Service department at 1-800-624-8822 for more information.*

6. How do I determine if the covered person is HMO or PPO if my office does not see the patient or the covered person identification card?

*Please check with your current software vendor and/or clearinghouse to find out if they offer the Electronic Eligibility and Verification Inquiry service. Another excellent free resource for determining covered person's coverage is available by logging into PacifiCare's Provider Portal at [www.pacificare.com](http://www.pacificare.com). You must first register on-line before receiving this information electronically. Please refer to page L-5 of this manual, "Electronic Eligibility Inquiry/Response", for further information.*

## EDI

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EDI  
Resources  
ContinuedFrequently  
Asked  
Questions  
(FAQs)  
Continued

7. How do I know if PacifiCare received my electronic file?

*You will receive an acknowledgement report from your clearinghouse. Depending on the clearinghouse, you may receive one acknowledgement that indicates the initial clearinghouse receipt of your file and another that confirms PacifiCare's receipt of your file. Please discuss acknowledgement report details with your clearinghouse.*

8. How can I find out the status of my submitted claims instead of calling the PacifiCare Customer Service line?

*Please check with your current software vendor and/or clearinghouse to find out if they offer the Electronic Claims Status and Inquiry service. Another excellent free resource for instantly tracking the status of your submitted claims is available by logging into PacifiCare's Provider Portal at [www.pacificare.com](http://www.pacificare.com). You must first register on-line before receiving this information electronically. Please refer to page L-5 of this manual, "Claims Status Inquiry/Response", for further information.*

9. What are the costs to Providers for submitting EDI claims through a PacifiCare-approved clearinghouse?

*With the exception of any required set-up and/or recurring monthly or annual fees, (if applicable), there is **no** transaction fee for Providers to transmit EDI claims through clearinghouses that have established direct EDI connectivity with PacifiCare (outlined on page L-2 of this manual, "**List of Clearinghouses**"). These PacifiCare-sponsored clearinghouses have agreed to waive the EDI claims transmission fee for their participating payers. Please contact the clearinghouse directly for further information.*

10. Can a Provider transmit EDI claims directly to PacifiCare without using a clearinghouse?

*PacifiCare prefers to conduct EDI business transactions primarily through clearinghouses. Clearinghouses normally have established EDI connections to many payers. This arrangement benefits the Providers by allowing transmission of EDI transactions to multiple payers, using a single connection.*

**EDI****Revised: 11/2005**

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**EDI  
Resources  
Continued****EDI  
Helpful  
Hints**

The following are additional EDI submission “Helpful Hints”:

- Work closely with your clearinghouse and practice management vendor to fully understand the reports they can offer you.
- Make it a priority to reconcile and review your reports to make sure your EDI claims are being accepted in order to be processed.
- Correct rejected claims in your practice management system, and resubmit them electronically for processing.
- Do not send any claims electronically that have been previously submitted on paper.

| Market     | Product Name   | Payer ID*  | Claim Address  |
|------------|--|--|--|
| Arizona    | PacifiCare SignatureOptions <sup>SM</sup> (PPO)<br>PacifiCare SignatureIndependence <sup>SM</sup> (Indemnity)  | 95999  | PO Box 6099<br>Cypress, CA 90630   |
|            | PacifiCare SignatureFreedom <sup>SM</sup> (SDHP)   | 95999  | (SDHP) Administrator/Synertech<br>PO Box 69312<br>Harrisburg, PA 17106-9312            |
|            | PacifiCare SignatureValue <sup>SM</sup> (HMO)<br>Medicare Advantage  | 95964  | PO Box 52078<br>Phoenix, AZ 85072-2078   |
|            | PacifiCare SignatureDirect <sup>SM</sup> (EPO)   | 95964  | PO Box 6099<br>Cypress, CA 90630   |
|            | PacifiCare Behavioral Health (PBH)   | 33053  | PO Box 31053<br>Laguna Hills, CA 92654-1053  |
|            | PacifiCare Encounters  | Write to: <a href="mailto:EncounterCollection@phs.com">EncounterCollection@phs.com</a> |  |
| California | PacifiCare SignatureOptions <sup>SM</sup> (PPO)  | 95999  | PO Box 6099 MS CY24-179<br>Cypress, CA 90630   |
|            | PacifiCare SignatureFreedom <sup>SM</sup> (SDHP)   | 95999  | (SDHP) Administrator/Synertech<br>PO Box 69312<br>Harrisburg, PA 17106-9312            |
|            | PacifiCare SignatureIndependence <sup>SM</sup> (Indemnity)   | 95999  | PO Box 6099<br>Cypress, CA 90630   |
|            | PacifiCare SignatureValue <sup>SM</sup> (HMO)<br>PacifiCare SignatureValueAdvantage <sup>SM</sup> (HMO)  | 95959  | PO Box 6006<br>Cypress, CA 90630   |
|            | Medicare Advantage   | 95959  | PO Box 489<br>Cypress, CA 90630-0489   |
|            | PacifiCare SignaturePOS <sup>SM</sup> (POS)  | 95959  | PO Box 6019<br>Cypress, CA 90630   |
|            | PacifiCare Behavioral Health (PBH)   | 33053  | PO Box 31053<br>Laguna Hills, CA 92654-1053  |
|            | PacifiCare Encounters  | Write to: <a href="mailto:EncounterCollection@phs.com">EncounterCollection@phs.com</a> |  |
| Colorado   | PacifiCare SignatureOptions <sup>SM</sup> (PPO)<br>PacifiCare SignatureIndependence <sup>SM</sup> (Indemnity)  | 95999  | PO Box 6099<br>Cypress, CA 90630   |
|            | PacifiCare SignatureFreedom <sup>SM</sup> (SDHP)   | 95999  | (SDHP) Administrator/Synertech<br>PO Box 69312<br>Harrisburg, PA 17106-9312            |
|            | PacifiCare SignatureValue <sup>SM</sup> (HMO)<br>Medicare Advantage<br>PacifiCare SignaturePOS <sup>SM</sup> (POS)                                       | 95962  | PO Box 6699<br>Englewood, CO 80155   |
|            | PacifiCare SignatureValueDirect <sup>SM</sup> (EPO)  | 95962  | PO Box 6099<br>Cypress, CA 90630   |
|            | PacifiCare Behavioral Health (PBH)   | 33053  | PO Box 31053<br>Laguna Hills, CA 92654-1053  |
|            | PacifiCare Encounters  | Write to: <a href="mailto:EncounterCollection@phs.com">EncounterCollection@phs.com</a> |  |
| Nevada     | PacifiCare SignatureOptions <sup>SM</sup> (PPO)<br>PacifiCare SignatureIndependence <sup>SM</sup><br>PacifiCare SignatureValueDirect <sup>SM</sup> (EPO) | 95999  | PO Box 6099<br>Cypress, CA 90630   |
|            | PacifiCare SignatureFreedom <sup>SM</sup> (SDHP)   | 95999  | (SDHP) Administrator/Synertech<br>PO Box 69312<br>Harrisburg, PA 17106-9312            |
|            | PacifiCare SignatureValue <sup>SM</sup> (HMO)<br>Secure Horizon <sup>®</sup> (Medicare + Choice)<br>PacifiCare SignaturePOS <sup>SM</sup> (POS)          |  | PO Box 95638<br>Las Vegas, NV 89193-5638<br><br>Call P5 Health Solution 1-888-478-7351 |

\*The Payer ID is an identification number that instructs the clearinghouse where to send your electronic claims/encounters. In some cases, the Payer ID listed above may be different from the numbers issued by your clearinghouse. To avoid processing delays, you must contact your clearinghouse for the appropriate PacifiCare Payer ID number or refer to your clearinghouse published Payer Lists.

*Figure L-1 EDI Quick Reference Tool EDI Payer ID Guide*

| Market                | Product Name  | Payer ID*                             | Claim Address  |
|-----------------------|---|---------------------------------------|--|
| Oklahoma              | PacifiCare SignatureOptions <sup>SM</sup> (PPO)<br>PacifiCare SignatureIndependence <sup>SM</sup> (Indemnity)   | 95999                                 | PO Box 6099<br>Cypress, CA 90630   |
|                       | PacifiCare SignatureFreedom <sup>SM</sup> (SDHP)  | 95999                                 | (SDHP) Administrator/Syneritech<br>PO Box 69312<br>Harrisburg, PA 17106-9312 |
|                       | PacifiCare SignatureValue <sup>SM</sup> (HMO)<br>Medicare Advantage<br>PacifiCare SignaturePOS <sup>SM</sup> (POS)  | 95959                                 | PO Box 40055<br>San Antonio, TX 78229  |
|                       | PacifiCare Behavioral Health (PBH)  | 33053                                 | PO Box 31053<br>Laguna Hills, CA 92654-1053                                  |
|                       | PacifiCare Encounters   | Write to: EncounterCollection@phs.com |  |
| Oregon                | PacifiCare SignatureOptions <sup>SM</sup> (PPO)<br>PacifiCare SignatureValueDirect <sup>SM</sup> (EPO)<br>PacifiCare SignatureValueAccess <sup>SM</sup> (EPO) | 95999                                 | PO Box 6099<br>Cypress, CA 90630   |
|                       | PacifiCare SignatureFreedom <sup>SM</sup> (SDHP)  | 95999                                 | (SDHP) Administrator/Syneritech<br>PO Box 69312<br>Harrisburg, PA 17106-9312 |
|                       | PacifiCare SignatureValue <sup>SM</sup> (HMO)   | 95959                                 | PO Box 6090<br>Cypress, CA 90630   |
|                       | PacifiCare SignaturePOS <sup>SM</sup> (POS)   | 95959                                 | PO Box 6092<br>Cypress, CA 90630   |
|                       | Medicare Advantage  | 95959                                 | PO Box 6006<br>Cypress, CA 90630   |
|                       | PacifiCare Behavioral Health (PBH)  | 33053                                 | PO Box 31053<br>Laguna Hills, CA 92654-1053                                  |
| PacifiCare Encounters | Write to: EncounterCollection@phs.com   |                                       |  |
| Texas                 | PacifiCare SignatureOptions <sup>SM</sup> (PPO)<br>PacifiCare SignatureIndependence <sup>SM</sup> (Indemnity)   | 95999                                 | PO Box 6099<br>Cypress, CA 90630   |
|                       | PacifiCare SignatureFreedom <sup>SM</sup> (SDHP)  | 95999                                 | (SDHP) Administrator/Syneritech<br>PO Box 69312<br>Harrisburg, PA 17106-9312 |
|                       | PacifiCare SignatureValue <sup>SM</sup> (HMO)<br>PacifiCare SignaturePOS <sup>SM</sup> (POS)<br>Medicare Advantage  | 95959                                 | PO Box 29127<br>San Antonio, TX 78229  |
|                       | PacifiCare Behavioral Health (PBH)  | 33053                                 | PO Box 31053<br>Laguna Hills, CA 92654-1053                                  |
|                       | PacifiCare Encounters   | Write to: EncounterCollection@phs.com |  |
| Washington            | PacifiCare SignatureOptions <sup>SM</sup> (PPO)<br>PacifiCare SignatureValueDirect <sup>SM</sup> (EPO)<br>PacifiCare SignatureValueAccess <sup>SM</sup> (EPO) | 95999                                 | PO Box 6099<br>Cypress, CA 90630   |
|                       | PacifiCare SignatureFreedom <sup>SM</sup> (SDHP)  | 95999                                 | (SDHP) Administrator/Syneritech<br>PO Box 69312<br>Harrisburg, PA 17106-9312 |
|                       | PacifiCare SignatureValue <sup>SM</sup> (HMO)<br>PacifiCare SignaturePOS <sup>SM</sup> (POS)  | 95959                                 | PO Box 6092<br>Cypress, CA 90630-0092  |
|                       | Medicare Advantage  | 95959                                 | PO Box 6093<br>Cypress, CA 90630-0093  |
|                       | PacifiCare Behavioral Health (PBH)  | 33053                                 | PO Box 31053<br>Laguna Hills, CA 92654-1053                                  |
|                       | PacifiCare Encounters   | Write to: EncounterCollection@phs.com |  |

\*The Payer ID is an identification number that instructs the clearinghouse where to send your electronic claims/encounters. In some cases, the Payer ID listed above may be different from the numbers issued by your clearinghouse. To avoid processing delays, you must contact your clearinghouse for the appropriate PacifiCare Payer ID number or refer to your clearinghouse published Payer Lists.

*Figure L-1 Quick Reference Tool EDI Payer ID Guide*

**Clinical Denials**

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**Revised: 06/2005**

Denials, Delays or Modifications .....M-1

Written Denial Notice .....M-3

Experimental/Investigational Services Denials .....M-4

Notice of Affirmative Statement Regarding Incentives .....M-6

Cancer Clinical Trials .....M-6

**Denials, Delays  
or  
Modifications**

Decisions to approve, modify or deny requests for authorization of health care services, based on medical necessity or benefit coverage, are made and communicated in a timely manner appropriate for the nature of the covered person's medical condition, in accordance with State-mandated timeliness standards.

All authorization decisions must be based on sound clinical evidence, including, but not limited to, review of medical records, consultation with the treating practitioners and review of nationally-recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system. All information to support decision-making shall be consistently gathered and documented.

Referral requests not meeting criteria must be reviewed by a Medical Management/Utilization Management (MM/UM)-designated physician or presented to the collective MM/UM or subcommittee for discussion and a determination. Only a physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may determine to delay, modify or deny services to a covered person for reasons of medical necessity. Board-certified, licensed physicians from appropriate specialty areas may be utilized to assist in making determinations of medical necessity, as appropriate.

- Physicians shall not review their own referral requests;
- Referral requests being considered for denial shall be discussed with physicians qualified to make an appropriate determination;
- Any referral request where the medical necessity or the proposed treatment plan is not clear shall be clarified and discussed with the requesting physician.

**Clinical Denials****Revised: 06/2005**

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**Denials, Delays** Possible request for authorization determinations include:**or****Modifications****Continued**

- Approved as requested – No changes;
- Approved as modified – Referral approved, but the requested Provider or treatment plan was modified. Denial letter must be sent if specific treatment modality is changed (e.g., requested chiropractic, approved physical therapy);
- Extension, if applicable per State regulation - Delay of decision regarding a specific service (e.g., need additional documentation or information or require consultation by an expert reviewer);
- Denied – Non-authorization of a request for health care services.

Reasons for denials of requests for services include, but are not limited to, the following:

- Not a covered benefit – the requested service(s) is a direct exclusion of benefits under the covered person's Evidence of Coverage - specific benefit exclusion must be noted;
- Not medically necessary or benefit coverage limitation – specify criteria or guidelines used in making the determination as it relates to the covered person's health condition;
- Covered person not eligible at the time of service;
- Benefit exhausted - include specific information as to what benefit was exhausted and when;
- Experimental or investigational procedure/treatment.

**Written Denial Notice**

The written denial notice serves many purposes and is an important component in the covered person's file. The denial letter serves to document the covered person, practitioner and facility notification of:

- The denial or modification of requested services;
- The basis of denial or modification, including medical necessity, benefit limitation or benefit exclusion;
- The appeal rights;
- An alternative treatment plan, if applicable;
- Benefit exhaustion or planned discharge date.

**Minimum Content of Written or Electronic Notification**

Written or electronic notice to deny or modify a request for authorization for health care services shall include the following:

- The specific service(s) denied;
- The specific reference to the Plan provisions to support the decision;
- The reason the service is being denied or modified, including:
  - a clear and concise explanation of the reasons for the decision, in sufficient detail so that all parties can understand the rationale behind the decision; and
  - a description of the criteria or guidelines used, reference to the benefit provision, protocol or other similar criterion on which the denial decision is based;
  - how that criteria applies to the covered person's condition.
- Notification that the covered person can obtain a free of charge copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
- Clinical reasons for decisions regarding medical necessity;
- Contractual rationale for benefit denials;
- Alternative treatment options offered, if applicable (NA for retrospective review);
- Appeals and grievances processes, including:
  - information regarding the covered person's right to appoint a representative to file an appeal on the covered person's behalf;
  - the covered person's right to submit written comments, documents or other additional relevant information;
  - information notifying the covered person and their treating practitioner of the right to an expedited appeal for time-sensitive situations (NA for retrospective review);

**Written Denial  
Notice  
Continued**

- information regarding the covered person's right to apply for an independent medical review process (IMR) as per State regulations;
- information that the covered person may bring civil action, under Section 502(a) of the Employee Retirement Income Security Act (ERISA);
- information regarding the Federal Employee Health Benefits Plan appeals process; and
- **For the requesting Provider:** the name and direct telephone number of the health care professional responsible for the decision. PacifiCare will distribute sample letter on a regular basis.

*Please contact your PacifiCare Clinical Management Specialist for additional information regarding these letters.*

**Experimental/  
Investigational  
Services  
Denials**

Some states have state regulations that require every health plan to provide opportunity for an independent, external review whenever an authorization for any drug, device, procedure or other therapy deemed experimental or investigational is denied to covered persons who have either a life-threatening or seriously debilitating disease or condition.

**Life Threatening** is defined as:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
- Diseases or conditions with potentially fatal outcomes, where the end-point of clinical intervention is survival.

**Seriously Debilitating** is defined as:

- Diseases or conditions that cause major irreversible morbidity.

Experimental or investigational therapies are any drug, device, treatment or procedure that meets one or more of the following criteria:

- It cannot be lawfully marketed without approval of the United States Federal Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;
- It is the subject of a current investigational new-drug or new-device application on file with the FDA;

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**Section M: Experimental/Investigational Services Denials Cont.****Clinical Denials****Revised: 06/2005**

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**Experimental/  
Investigational  
Services  
Denials  
Continued**

- It is being provided pursuant to Phase I or Phase II clinical trials or as the experimental or research arm of a Phase III clinical trial, as the Phases are defined by regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS);
- It is being provided pursuant to written protocol that describes among its objectives determinations of safety and/or efficacy as compared with standard means of treatment;
- It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by Federal regulations and other official actions and publications issued by the FDA and HHS;
- The predominant opinion among experts as expressed in the published authoritative literature is that the usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
- It is not investigational or experimental in itself, as defined above, and would not be medically necessary, except for the provision of a drug, device, treatment or procedure that is investigational or experimental.

PacifiCare will issue a determination letter to the covered person and the requesting Provider. The experimental/investigational denial notice requires disclosure of additional rights and information regarding the independent external review process, which includes:

- An Independent Medical Review (IMR) packet;
- Physician certification form.

The practitioner denial notice also includes the experimental/investigational information packet.

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**Section M: Notice of Affirmative Statement Regarding Incentives  
Cancer Clinical Trials**

**Clinical Denials**

**Revised: 06/2005**

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**Notice of  
Affirmative  
Statement  
Regarding  
Incentives**

It is the policy of PacifiCare Health Systems to implement processes to help ensure that the health care-related decisions of PacifiCare consistently meet applicable legal, regulatory and contractual requirements and promote continuous quality improvement.

NCQA accreditation standards require that all health care organizations, health plans and MG/IPAs distribute a statement to all covered persons and to all practitioners, providers and employees who make UM decisions affirming the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage;
- Practitioners or other individuals are not specifically rewarded for issuing denials of coverage or service;
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

**Cancer  
Clinical Trials**

Some states have state regulations that require health plans to provide coverage for all routine patient care costs related to the clinical trial for covered persons diagnosed with cancer and accepted into a Phase I, Phase II, Phase III or Phase IV cancer clinical trial.

The covered person's treating participating practitioner, who is providing covered health care services to the covered person under the covered person's PacifiCare health plan, must recommend participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the covered person.

The Provider must forward referral requests for cancer clinical trials and all relevant case documentation to PacifiCare for review and determination. PacifiCare will issue a written determination notice to the covered person and the requesting Provider.

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**Additional Products****Revised: 11/2005**

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**Additional Products**

**Revised: 11/2005**

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**Additional Products**

**Revised: 11/2005**

**PacifiCare  
SignatureFreedom<sup>SM</sup>  
Product Overview**

PacifiCare's SignatureFreedom<sup>SM</sup> is a combination of a self directed account and a traditional PPO plan that is designed to engage consumers in actively managing their healthcare. This product is similar to a traditional PPO plan in that the enrollee may elect to receive services from any participating or non-participating healthcare provider.

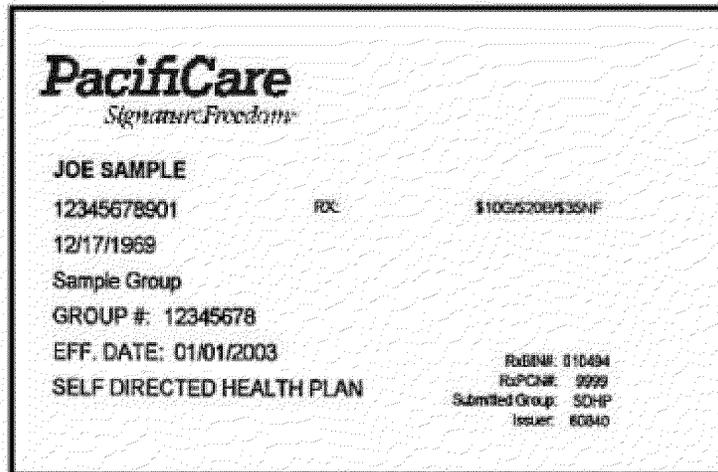
**Customer Service**

The PacifiCare SignatureFreedom<sup>SM</sup> product is fully supported by a dedicated Customer Service Unit that can be reached at:

**1-866-867-0700**

**Membership Card**

A copy of the PacifiCare SignatureFreedom<sup>SM</sup> Member identification card is located below:



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**Additional Products****Revised: 11/2005**

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**Provider Network** PacifiCare SignatureFreedom<sup>SM</sup> enrollees have access to all PacifiCare contracted PPO providers, as well as non-contracted providers.

**Self Directed Account (SDA)** PacifiCare's SignatureFreedom<sup>SM</sup> Plan provides the enrollee with a self directed account (SDA) that funds the enrollee's healthcare services. The enrollee controls use of the funds by electing when and where to receive care. Claims are paid out of the enrollee's SDA. Once the SDA is exhausted, the enrollee becomes financially responsible for the cost of services until the annual deductible has been satisfied. At that point, the SDHP functions in the same manner as PacifiCare's traditional PPO Plan.

**Prior Authorization** Certain services identified on the Prior Authorization Grid located on page N-15, require prior authorization by PacifiCare. To request prior authorization, contact PacifiCare at:

**866-867-0700**

Be prepared to provide the Customer Service Representative with the following information:

- Member name
- Member identification number
- Services requested
- Name of provider of service
- Phone number of provider of service

**Claims and Billing** Claims for services rendered to PacifiCare SignatureFreedom<sup>SM</sup> enrollees are administered by Synertech and should be sent to:

PacifiCare Health Plan Administrators  
P.O. Box 69312  
Harrisburg, PA 17106-9312

**Additional Products**

**Revised: 11/2005**

**PacifiCare  
SignatureOptions<sup>SM</sup>  
Product Overview**

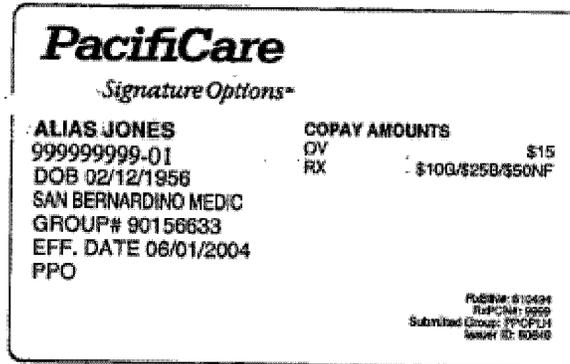
PacifiCare's SignatureOptions<sup>SM</sup> is a Preferred Provider Organization (PPO) product that offers the Member the option of choosing any physician within the PacifiCare participating network or any out-of-network physician. The Member's out-of-pocket expenses depend on whether the Member receives care from within the PPO network or from an out-of-network physician.

**Eligibility &  
Customer Service**

PacifiCare's PPO Interactive Voice Response (IVR) is available 24 hours a day, 7 days a week to check eligibility, verify benefits and request prior authorization. The PacifiCare Regional Customer Service Center is available to provide customer service and to assist you with any questions about the product. Contact the Regional Customer Service Center and/or the IVR at:

**1-866-316-9776**

A copy of the PacifiCare SignatureOptions<sup>SM</sup> Member identification card is located below:



**Benefits**

Members can elect to receive care from any primary care or specialty physician within the PPO participating network or from an out-of-network physician. Members do not need a referral authorization to receive care from a specialist. Based on the benefit plan purchased by the employer, the Member will be responsible for a deductible and/or a coinsurance.

**Prior  
Authorization**

Certain services identified on the Prior Authorization Grid located on page N-13, require prior authorization by PacifiCare. To request prior authorization, contact the Regional Customer Service Center at:

**1-866-316-9776**

**1-866-863-9776 (Prior Authorization only)**

or, fax the authorization request to PacifiCare at:

**1-800-457-3825**

Authorization requests must include the following information:

- Member name
- Member identification number
- Services requested
- Name of provider of service
- Phone number of provider of service

**Claims and  
Billing**

PacifiCare is financially responsible for all claims for Members enrolled in the PPO product. All claims should be submitted to:

PacifiCare  
PPO Regional Customer Service Center  
P.O. Box 6099  
Cypress, CA 90630

To submit claims via electronic data interchange, you must use EDI Payor ID 95999. Direct all questions about EDI submissions to PacifiCare's EDI unit at [Edisupport@phs.com](mailto:Edisupport@phs.com) or by phone at **800-203-7729**.

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**Section: N PacifiCare SignatureValue<sup>SM</sup> Access Product Overview  
Eligibility & Customer Service**

**Additional Products**

**Revised: 11/2005**

**PacifiCare  
SignatureValue<sup>SM</sup>  
Access Product  
Overview**

PacifiCare's SignatureValue<sup>SM</sup> Access is an Exclusive Provider Organization (EPO) product. PacifiCare's SignatureValue<sup>SM</sup> Access is an EPO product that is self-insured. The employer group funds the claims pool for the self-insured product. These EPO products offer open access to a network comprised of PacifiCare's contracted PPO physician network and its contracted HMO hospital network.

**Eligibility &  
Customer  
Service**

PacifiCare's Interactive Voice Response (IVR) is available 24 hours a day, 7 days a week to check eligibility, verify benefits and request prior authorization. Contact the IVR at:

**1-866-316-9776**

**1-866-863-9776 (Prior Authorization only)**

A copy of the PacifiCare SignatureValue<sup>SM</sup> Access Member identification card is located below. The identification card provides the following information:

- Member name
- Member identification number
- Date of birth
- Group name
- Group number
- Effective date
- Office visit copayment
- Emergency room copayment
- Hospital copayment
- Pharmacy copayment, if applicable

|   |                            |
|---|----------------------------|
| <b>PacifiCare</b><br><i>SignatureValue<sup>SM</sup></i> | <b>Access</b>              |
| Jane Q. Sample  | <b>COPAY AMOUNTS</b>       |
| 1234567-01  | OV \$xxx                   |
| DOB 11/14/54  | ER \$xxx                   |
| GROUP NAME  | HOSP \$xxx                 |
| GROUP NUMBER  | Rx - G/B/NF \$xx/\$xx/\$xx |
| EFFECTIVE DATE 1/01/04                                  | RxBIN# 610494              |
|   | RxPCN# 9999                |
|   | Submitted Group: PPOPLAC   |
|   | Issuer: 80840              |

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**Additional Products****Revised: 11/2005**

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**Benefits**

The EPO product provides in-network coverage with an open access feature. Members can elect to receive care from any primary care or specialty physician within the designated network. Members do not need a referral authorization to receive care from a specialist.

Out-of-network services are not covered, except emergency services and urgently needed services.

**Prior  
Authorization**

Certain services identified on the Prior Authorization Grid located on page N-13, require prior authorization by PacifiCare. To request prior authorization, contact PacifiCare at:

**1-866-863-9776**

or, fax the authorization request to PacifiCare at:

**1-800-457-3825**

Emergency hospital admissions must be reported within two (2) business days following the admission. For non-emergency authorization, requests must include the following information:

- Member name
- Member identification number
- Services requested
- Name of provider of service
- Phone number of provider of service

**Claims and  
Billing**

PacifiCare is financially responsible for all claims for Members enrolled in the EPO products. All claims should be submitted to:

PacifiCare  
Customer Service Center  
P.O. Box 9035  
Cypress, CA 90630

# Section: N PacifiCare SignatureIndependence<sup>SM</sup> Product Overview Eligibility & Customer Service

## Additional Products

Revised: 11/2005

### PacifiCare SignatureIndependence<sup>SM</sup> Product Overview

PacifiCare's SignatureIndependence<sup>SM</sup> is an Indemnity product that offers the Member the option of choosing any licensed physician within the United States. The Member's out-of-pocket expenses are determined by their deductible and coinsurance level.

### Eligibility & Customer Service

PacifiCare's Indemnity Interactive Voice Response (IVR) is available 24 hours a day, 7 days a week to check eligibility, verify benefits and request prior authorization. The PacifiCare Regional Customer Service Center is available to provide customer service and to assist you with any questions about the product. Contact the Regional Customer Service Center and/or the IVR at:

**1-866-316-9776**

A copy of the PacifiCare SignatureIndependence<sup>SM</sup> Member identification card is located below:

|  |   |
|--|---|
| <b>PacifiCare</b><br><i>SignatureIndependence<sup>SM</sup></i>                       |   |
| <b>JEAN C. PUBLIC</b><br>ADVENTURE 16<br>123456789<br>DOB 8/2/78<br>EFF. DATE 7/1/03 | <b>COPAY AMOUNTS</b><br>Rx \$100/\$500/\$1000<br><br>F0B1N#: 610494<br>RUPCNE: 9999<br>Submitted Group: 9999<br>Issuer: 90840 |

|  |
|--|
| <p><a href="http://www.pacificare.com">www.pacificare.com</a></p> <p><b>EMERGENCY SERVICES:</b> Call 911 or go to your nearest emergency room. Notify Company within 2 business days of admission to a hospital.</p> <p><b>NON-EMERGENCY:</b> To avoid additional expense, obtain preauthorization 3 days before receiving specified services by calling 1-800-xxx-xxxx.</p> <p><b>CUSTOMER SERVICE DEPARTMENT:</b> 1-800-xxx-xxxx, 1-800-xxx-xxxx (TDWI)<br/>Monday through Friday, 7:00 a.m. to 9:00 p.m.<br/>Send claims to: P.O. Box xxx, City, State, ZIP<br/>Send other inquiries to: P.O. Box xxx, City, State, ZIP</p> <p><b>NOTICE TO PROVIDERS</b><br/>Possession of this card does not guarantee eligibility.<br/>To confirm eligibility, call: 1-800-xxx-xxxx.</p> <p><small>Underwritten by xxx<br/>Prescription benefits administered by Prescription Solutions<sup>SM</sup></small></p> |
|--|

**Benefits**

Members can elect to receive care from any licensed physician within United States. Members do not need a referral authorization to receive care from a specialist. Based on the benefit plan purchased by the employer, the Member will be responsible for a deductible and/or a coinsurance.

**Prior  
Authorization**

Certain services identified on the Prior Authorization Grid located on page N-13, require prior authorization by PacifiCare. To request prior authorization, contact the Regional Customer Service Center at:

**1-866-316-9776**

**1-866-863-9776 (Prior Authorization only)**

or, fax the authorization request to PacifiCare at:

**1-800-457-3825**

Authorization requests must include the following information:

- Member name
- Member identification number
- Services requested
- Name of provider of service
- Phone number of provider of service

**Claims and  
Billing**

PacifiCare is financially responsible for all claims for Members enrolled in the Indemnity product. All claims should be submitted to:

PacifiCare

Indemnity Regional Customer Service Center

P.O. Box 6099

Cypress, CA 90630

To submit claims via electronic data interchange, you must use EDI Payor ID 95999. Direct all questions about EDI submissions to PacifiCare's EDI unit at [Edisupport@phs.com](mailto:Edisupport@phs.com) or by phone at **800-203-7729**.

**Additional Products**

**Revised: 11/2005**

**PacifiCare  
SignatureOptions  
(HSA-Compatible  
PPO) Product  
Overview**

PacifiCare's SignatureOptions (HSA-Compatible PPO)<sup>SM</sup> is a PPO-based product that offers the Member the option of choosing any physician within the PacifiCare participating network or any out-of-network physician. The Member's out-of-pocket expenses depend on whether the Member receives care from within the PPO network or from an out-of-network physician.

**Health Savings  
Account (HSA)**

PacifiCare's SignatureOptions (HSA-Compatible PPO)<sup>SM</sup> Plan provides the enrollee with a health savings account (SDA) from which enrollees may pay for healthcare services directly out of their account via a check or debit card.

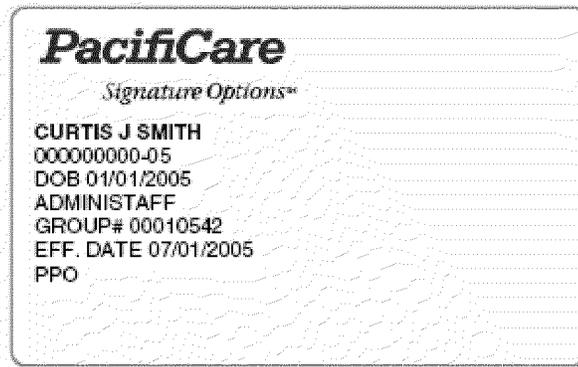
The enrollee is financially responsible for the cost of services until the annual deductible has been satisfied. At that point, the HSA-Compatible PPO functions in the same manner as PacifiCare's traditional PPO Plan.

**Eligibility &  
Customer Service**

PacifiCare's PPO Interactive Voice Response (IVR) is available 24 hours a day, 7 days a week to check eligibility, verify benefits and request prior authorization. The PacifiCare Regional Customer Service Center is available to provide customer service and to assist you with any questions about the product. Contact the Regional Customer Service Center and/or the IVR at:

**1-866-316-9776**

A copy of the PacifiCare SignatureOptions (HSA-Compatible PPO)<sup>SM</sup> Member identification card is located below:



**Benefits**

Members can elect to receive care from any primary care or specialty physician within the PPO participating network or from an out-of-network physician. Members do not need a referral authorization to receive care from a specialist. Based on the benefit plan purchased by the employer, the Member will be responsible for a deductible and/or a coinsurance.

**Prior  
Authorization**

Certain services identified on the Prior Authorization Grid located on page N-13, require prior authorization by PacifiCare. To request prior authorization, contact the Regional Customer Service Center at:

**1-866-316-9776**

**1-866-863-9776 (Prior Authorization only)**

or, fax the authorization request to PacifiCare at:

**1-800-457-3825**

Authorization requests must include the following information:

- Member name
- Member identification number
- Services requested
- Name of provider of service
- Phone number of provider of service

**Claims and  
Billing**

PacifiCare is financially responsible for all claims for Members enrolled in the Indemnity product. All claims should be submitted to:

PacifiCare  
Indemnity Regional Customer Service Center  
P.O. Box 6099  
Cypress, CA 90630

To submit claims via electronic data interchange, you must use EDI Payor ID 95999. Direct all questions about EDI submissions to PacifiCare's EDI unit at [Edisupport@phs.com](mailto:Edisupport@phs.com) or by phone at **800-203-7729**.

**SecureHorizons Direct<sup>SM</sup>** SecureHorizons Direct<sup>SM</sup> is a Private Fee For Service (PFFS) plan offered by PacifiCare Life and Health Insurance Company (PLHIC) under contract with the Centers for Medicare and Medicaid Services (CMS). The PFFS plan offers comprehensive health services to Medicare beneficiaries who enroll in SecureHorizons Direct<sup>SM</sup>.

**Benefits of provider participation:**

- There is no contract to sign, no network to join
- No prior authorization requirements for an Enrollee to see a specialist
- Enrollees have lower cost-sharing, which means they can get the care they need without worrying about out-of-pocket expenses
- No extra paperwork
- No waiting for secondary reimbursement from a Med Supp carrier

**Advantages for Enrollees:**

- In general, lower monthly premiums than Medicare Supplement plans
- Freedom to choose any physician in the state
- More benefits than Original Medicare
- No Medicare Part A or Part B deductibles
- No medical or health questionnaire required to qualify for coverage
- Low or no copayments for medical services

**Eligibility &  
Customer  
Service**

Providers should contact SecureHorizons Direct<sup>SM</sup> to verify eligibility, and to request information about covered benefits or copayments. Contact SecureHorizons Direct<sup>SM</sup> at:

**1-866-877-9386  
8:00 a.m. – 8:00 p.m. EST**

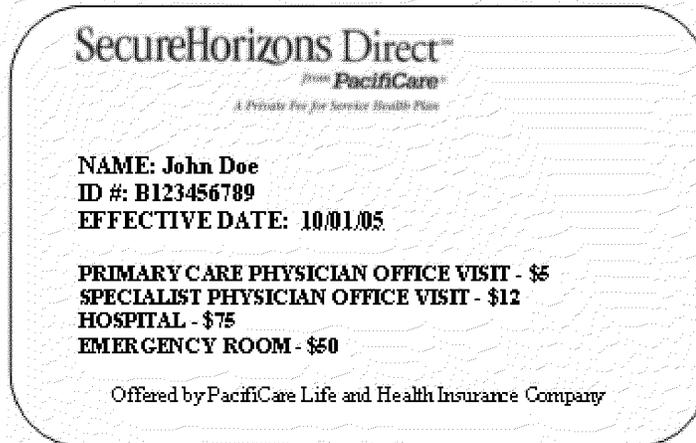
**Additional Products**

**Revised: 11/2005**

**Eligibility &  
Customer  
Service  
Continued**

A copy of the SecureHorizons Direct<sup>SM</sup> member identification card is located below. The identification card provides the following information:

- Member name
- Member identification number
- Primary care physician office visit copayment
- Specialist office visit copayment
- Emergency room office visit copayment
- Hospital copayment



**Claims and  
Billing**

SecureHorizons Direct<sup>SM</sup> is financially responsible for claims for all covered medical services provided to enrollees. All claims should be submitted to:

**SecureHorizons Direct<sup>SM</sup>**  
**P.O. Box 4169**  
**Scranton, PA 18505**

**PacifiCare  
Senior  
Supplement  
Product  
Overview**

PacifiCare's Senior Supplement Product is offered by PacifiCare Life and Health Insurance Company (PLHIC) for employer groups who want to provide their Medicare eligible retirees with a benefit to help cover healthcare costs above what Medicare pays.

**Benefits of provider participation:**

- There is no contract to sign, no network to join
- No prior authorization requirements for an Enrollee to see a specialist
- Enrollees have lower cost-sharing, which means they can get the care they need without worrying about out-of-pocket expenses

**Advantages for Enrollees:**

- Freedom to choose any physician or hospital that accepts Medicare
- Richer benefits and additional value-added services that are not available through original Medicare.

**Eligibility &  
Customer  
Service**

Providers should contact PacifiCare Senior Supplement to verify eligibility, and to request information about covered benefits or copayments at:

1-800-851-3802  
7:00 a.m. – 9:00 p.m. PST

A copy of the PacifiCare Senior Supplement member identification card is located below. The identification card provides the following information:

- Member name
- Member identification number
- Group # and Group Name

Eligibility &  
Customer  
Service  
Continued

04-02-1933  
12345678901201-1008:

**PacifiCare**<sup>®</sup>  
*Retiree Plans*<sup>™</sup>

Senior  
Supplement Plan

JOHN Q. SAMPLE

RIN- 610494

DOB:

: 9999

EF

IVE DATE: \$10G/\$20B/\$35N

MITTED GROUP: [0000000]

[ COPAYMENT AMOUNTS  
RX: ]

12345678

GROUP #:

Baptist General Convention OK

GROUP NAME:

UNDERWRITTEN BY: [PacifiCare Life and Health Insurance Company]

Claims and  
Billing

PacifiCare Senior Supplement is financially responsible for claims for all covered medical services provided to Enrollees. All claims should be submitted to:

PacifiCare Senior Supplement Plan  
P.O. Box 6072  
Cypress, CA 90630-0072



**CORPORATE MEDICAL MANAGEMENT  
2005 PRIOR-AUTHORIZATION LIST – HMO (CO & SH)\***



**INCLUSION OF ITEMS / SERVICES ON THIS LIST DOES NOT INDICATE BENEFIT COVERAGE. VERIFY BENEFITS PRIOR TO REQUESTING AUTHORIZATION.**

**INDEPENDENT FROM PRIOR-AUTHORIZATION, NOTIFICATION BY THE FACILITY IS REQUIRED FOR INPATIENT ADMISSIONS  
ON THE DAY OF ADMISSION: URGENT / EMERGENT, SCHEDULED / ELECTIVE MEDICAL/SURGICAL, OOA, HOSPICE AND OB SERVICES.**

**OUT OF NETWORK SERVICES / REFERRALS / TREATMENTS**

- All Out-Of-Network Hospitalizations, Surgeries, Procedures, Referrals, Evaluations, Services &/or Treatment

**INPATIENT, INSTITUTIONAL**

- Elective / Scheduled Medical Admissions
- Surgical Admissions: Surgical procedures do not require prior-authorization unless identified below.
- Acute Rehabilitation Admissions
- Post-Acute Admissions (Sub-Acute, SNF, Long-Term Acute Care)
- Admissions for Alcohol, Drug &/or Substance Abuse
- Mental Illness Admissions

**TREATMENTS RELATED TO THE FOLLOWING SERVICES**

- Transplants: BMT and Solid Organ
- Investigational or Experimental
- Clinical Trials: Prior-authorization is required for Commercial Members. Notification only is required for Secure Members.
- Implantable Cardioverter Defibrillators: Prior-authorization required for Secure Horizons members only, except as noted under the 'Additional State Specific' requirements.
- New Services & Technology

**SURGICAL PROCEDURES (Inpatient or Outpatient Services) \***

- Bariatric Surgery
- Cochlear Implant
- Infertility Procedures
- Orthognathic Surgery
- Pain Management Procedures
- Plastic, Reconstructive, and/or Cosmetic Procedures
- Spinal Surgeries
- Total Joint Replacements
- Uvulopalatopharyngoplasty (UPPP)
- Vein Procedures

**OUTPATIENT SERVICES/TREATMENT (Outpatient, Office & Related Services) \***

- Cardiac Rehabilitation
- Dental Anesthesia
- Durable Medical Equipment (DME) > \$800 billed charge per device
- External Counterpulsation (EECP)
- Home Health Care
- Hyperbaric Oxygen Therapy
- Injectables and Home Infusions per Injectable PA List
- Liquid Oxygen
- Orthotics: All foot orthotics regardless of billed charge, or any other orthotic device > \$800 billed charge per device
- Pain Management Programs
- Prosthetics > \$800 billed charge per device
- Pulmonary Rehabilitation
- Sleep Studies
- Therapies: PT, OT, ST

**RADIOLOGY SERVICES \***

- CT: Head, Abdomen
- PET
- SPECT: Heart, Brain, Other
- MRI: Brain, Joint, Spine
- Proton Beam Treatment

**TRANSPORTS**

- Air Ambulance Transports

**ADDITIONAL INFORMATION & INDIVIDUAL STATE REQUIREMENTS**

**ARIZONA** (Effective date of this list: 8/01/2005)

- **DME/Liquid Oxygen** if services are not provided by Apris or are Off-Cap & greater than \$800.
- **Home Health Services**: if services are not provided by Gentiva
- **Therapies** (PT, OT, ST) if services are not provided through Rehab Provider Network of AZ.

**COLORADO** (Effective date of this list: 8/01/2005)

- **Chiropractic Services**
- **Ophthalmology**
- **Outpatient Mental Health Services**
- **Radiology Services**: The following services require PA: CT, MRI, MRA, Nuclear Medicine, PET & SPECT. Contact [MedSolutions.com](http://MedSolutions.com), at 888-693-3211

**OKLAHOMA & TEXAS**

- (Effective date of this list: 9/01/2005)
- **TEXAS**: Prior-authorization will not be required for Therapies (PT, OT, ST) in accordance with State regulations.

**CALIFORNIA** (Effective date of this list: 8/01/2005)

- NEVADA**: This list is not applicable to NV members
- HMO & POS (Tier 1): Contact P5 for prior-authorization Phone: 702-318-2400, Fax: 702-318-2404 or 702-318-2497
- POS (Tier 2 & 3): Contact PacifiCare for prior-authorization. Phone: 702-269-2870 or 800-337-8114

**OREGON & WASHINGTON**

- (Effective date of this list: 8/01/2005)
- **Cardiac Procedures**: CABG, Cardiac Pacemaker, Implantable Defibrillators, Cardiac Valve Replacement

\* State specific prior-authorization requirements exist. Refer to the 'Additional Information' section above or the State's individual prior-auth list located on the Provider Portal.

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**Purpose / Overview**

The purpose of this section is to provide an overview of PacifiCare's Provider Portal password-protected web site for providers that can be accessed at [www.pacificare.com](http://www.pacificare.com). For PacifiCare participating providers, the Provider Portal offers access to the following information 24 hours a day, 7 days a week, including, but not limited to:

- **Capitation Reports (as applicable per region)**
- Check Claims Status
- Commonly Requested Forms
- Eligibility Information
- Formulary
- iEXCHANGE (Hospital Admissions, Authorizations & Referrals) **(as applicable per region)**
- Provider Directory
- Provider Policy and Procedure Manuals
- Retail Pharmacy Directory
- Library / Resource Center

**Provider Portal  
Registration /  
Accessing the  
Provider Portal**

To register for the PacifiCare Provider Portal:

1. Type [www.pacificare.com](http://www.pacificare.com) in your Internet browser
2. Press "Go" or "Enter"
3. Click on "Provider"
4. Click on the "Register" tab at the top of the page;
5. Click on the "Register with PacifiCare ID" tab or "Register with Tax ID" tab in the left navigation menu;
6. Complete the required fields;
7. Click on "Submit";
8. Once submitted, your password will arrive in the mail within five to seven (5-7) business days.

Benefits of registration:

- Faster, accurate claims status and eligibility information available 24 hours a day, 7 days a week;
- Get a printable response directly from PacifiCare's information system;

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## **Section O: Provider Portal Registration/Accessing Portal Cont. Forgotten Provider ID/Password**

### **Provider Portal**

**Revision Date: 08/2005**

#### **Provider Portal Registration / Accessing the Portal Continued**

- Check eligibility for ten (10) members at a time instead of one after the other;
- Get the latest forms online whenever you need them;
- Contact Network Management or Customer Service using secure e-mail, by clicking on the “Contact Us” link at the top right of the screen to access state-specific contact information.

Once registered, log in to receive critical services only available to authenticated users by following these steps:

1. Type www.pacificare.com in your Internet Browser
2. Press “Go” or “Enter”
3. Click on “Provider”
4. Click on the “Log In” button at the top right of the screen;
5. Enter User ID and Password;
6. Select your state;
7. Click “Log In” button at bottom of the screen to submit.

#### **Forgotten Provider ID / Password**

If you forgot your Provider ID, click on the “Forgot User ID” link and follow the steps. Your Provider ID will be e-mailed to you if you entered your e-mail address at the time of registration. You can also call 800-693-8322 and a representative will retrieve your Provider ID and assign a temporary password. Provider IDs cannot be reset. Passwords may be reset if you answer your security questions that you answered during your first log in.

If you forgot your password, select the “Forgot Password” link and follow the steps. The security questions that you answered during your first log in will appear. After answering the questions, you can then change your password. If you are not successful in resetting your password, call 800-693-8322 and a representative will assign a temporary password.

Please note that resetting the password does NOT impact other users that you may have set up (see Manage My Users in this Section of the Manual).

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**Section O: Links Available Before and After Log In**  
**Links Available After Log In**  
**Manage My Users**

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**Provider Portal** **Revision Date: 08/2005**

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**Links Available Before and After Log In** The following links are available before and after log in:

1. **EDI** – can be found under: *Library/Resource Center/EDI and Clearinghouse Information*
2. **iEXCHANGE** (Hospital Admissions, Open Auths & Referrals Before: *Home Page/Quick Links/iEXCHANGE*  
After: *Services & Tools/iEXCHANGE*)
3. **Product Plan Overview**  
Before: *Doing Business with Us/Product Plan Overview*  
*Home Page/Quick Links/Product Plan Overview. This quick link is also available before login.*
4. **Virtual Tour** – can be found under: *Help Link/Virtual Tour* – helps you navigate easily. It’s also there in the Log In page
5. **Directories**-can be found on the home page.

**Links Available After Log In** The following links are available after log in:

1. **Provider Manuals**
2. **Plan Schedules & Codes**
3. **Reports**
4. **Commonly Used Forms**
5. **Manage My Users**
6. **Eligibility**
7. **Claim Status**

**Manage My Users** This function gives an office administrator the ability to create, modify and delete individual user accounts for office staff to control access to Member information through PacifiCare’s web portal. It also gives the office administrator the ability to reset forgotten passwords for the user accounts created.

To create a new user or edit an existing user, select from one of the two links located on the left side of the screen. The following is a brief overview of each major function that “Manage My Users” provides:

- **Create User:** Allows the ability to create a new user and assign them one or more roles;

**Manage My Users  
Continued**

- **User Admin:** Provides an administrative view of all users in the office. From here:
  1. Detailed information about a user can be viewed;
  2. User information can be edited;
  3. Passwords can be reset;
  4. Individual users can be deleted.

Users created by the administrator should be assigned a role with only the lowest level of permission to do their job. PacifiCare.com then limits what users view based on their defined role. For example, a user with a “Check Eligibility” role sees only eligibility information within PacifiCare.com, whereas a user with a “Claims Status Checker” role has access to both claims status and eligibility.

PacifiCare provides this functionality to meet our joint responsibilities of HIPAA Privacy and Security compliance.

**Accessing Help  
Functions**

The following features are available and are accessed by clicking on “Help”:

1. A list of Frequently Asked Questions (FAQs)
2. A Quick Reference Guide
3. A Virtual Tour that will walk you through the features and functionality of the Provider Portal

**Accessing Capitation  
Reports**

To access Capitation reports, follow these steps:

1. Click on the “Services and Tools” tab;
2. Click on “Reports” on the left navigation menu;
3. Click on any report of interest;
4. Open and view report or save it to your hard drive.

**Accessing Claims  
Functions**

To check claims status, follow these steps:

1. Click on “Check Claim Status” tab;
2. Click “OK” to accept disclaimer;
3. Fill in required fields;
4. Click on “Submit”;
5. Click on underlined claim number to view additional details.

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**Section O:                      Accessing Most Utilized Forms & Critical Info**  
**Accessing Eligibility Information**  
**Accessing the Formulary**  
**Accessing iEXCHANGE**

**Provider Portal**

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**Accessing Most Utilized Forms and Critical Information**

Forms can be accessed under the “Library” tab by clicking on the “Forms” link. In addition to many commonly used forms, you will also find the following, including, but not limited to:

1. Guidelines and Interpretation Manuals
2. Member Health Programs
3. Plan Schedules and Codes
4. Provider Policy and Procedure Manuals
5. Publications
6. Quality Index Profile
7. Pharmacy
8. Resource Center

**Accessing Eligibility Information**

To check eligibility of a Member, follow these steps:

1. Click on the “Check Eligibility” tab;
2. Enter Member ID, dates of service and state (for up to ten (10) inquiries);
3. Click on “Submit”;
4. Click on underlined Member IDs to view benefit details;
5. Click on bar to view details.

**Accessing the Formulary**

To access the PacifiCare Formulary, follow these steps:

1. Click on the “Pharmacy” link under the “Library” tab;
2. Click on “Pharmacy” on the left navigation menu;
3. Click on formulary of interest

From the “Pharmacy” link, you can also access pharmacy forms, selected medication lists and obtain information on PacifiCare’s pharmacy mail service, RxSolutions.

**Accessing iEXCHANGE (Hospital Admissions, Authorizations & Referrals)**

*For AZ, NV & CO states: iExchange is not available until late 2006. Please contact your network management operations associate for more information regarding availability and how to gain access at that time.*

iEXCHANGE™ from MEDecision, is a new, no-cost application that allows PacifiCare providers to submit online prior authorization requests and inpatient admission notifications using the Internet.

Some of the benefits of this application include:

- Ability to request prior authorization and extensions directly to PacifiCare and receive immediate status feedback.

**Accessing  
iEXCHANGE  
(Hospital Admissions,  
Authorizations &  
Referrals)  
Continued**

- Status is either auto-approved or pending. Pending requests are immediately forwarded to Medical Management which will review the request and respond.
- All requests are immediately available in PacifiCare's care management system which provides a more timely response to you.
- Receipt of a tracking number upon submission of request.
- Once a request is submitted, a system-generated tracking number is given that can be used to track the case status or request any future service extensions to the initial requests
- Alerts from PacifiCare when a request is reviewed and updated by the Medical Management department.
- Ability to provide clinical notes to PacifiCare in a comments section
- Ability to check Managed Care member/enrollee eligibility and look up existing authorizations online
- Ability to submit inpatient admission notifications and outpatient authorization information for Managed Care Members.
- Print a copy of authorization requests to give to another provider, a member or for provider files.

To access iEXCHANGE, follow these steps:

1. Click on the "Services and Tools" tab;
2. Click on the "iEXCHANGE (Hospital Admissions, Open Auths & Referrals)" link;
3. Click "I Accept" to accept disclaimer.

This will take you to the iEXCHANGE/MEDecision welcome page, which contains instructions on how to proceed.

For information on how to sign up for this application, please contact your PacifiCare Network Management Operations Associate directly who can assist you or call the appropriate regional number to request access.

For CA, OR, & WA states: 1-800-693-8322  
For TX & OK states: 1-877-847-2862

Please ensure that you access iEXCHANGE via the portal every time you log-in to ensure you are accessing the most up-to-date version. Do not save the link as a favorite.

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## **Section O: Accessing the Provider Directory/Retail Pharmacy State Specific Portal Functionality**

### **Provider Portal**

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#### **Accessing the Provider Directory / Retail Pharmacy Directory**

To access the Directories, follow these steps:

1. Click on the “Directories” tab;
2. From the left navigation menu:
  - Choose “Physicians in our Network” for the provider directory;
  - Choose “Retail Pharmacies in our Network” for the retail pharmacy directory;

#### **State Specific Portal Functionality**

The Provider Portal provides the following additional functions as applicable per state, which includes but is not limited to the following:

##### **All regions:**

- Continuing Medical Education
- EDI and Clearinghouse Information
- IVR System Options
- Medicare Physician Fee Schedule Look Up
- Physician Services
- Product Information

##### **Arizona only:**

- Arizona Network News
- Clinical Practices
- Provider Manual and Administrative Forms
- Provider Handbook and Specialty Referral List

##### **California only:**

- Provider Links
- Provider Disputes
- Specialty Referral List

##### **Colorado only:**

- FAQ Express Referrals Program

##### **Nevada Only**

- Nevada Network News

##### **Oklahoma and Texas only:**

- Evidence of Coverage

The above information is located under the Resource Center. Follow these steps:

1. Click on the “Library” tab;
2. From the left navigation menu, choose “Resource Center” to access the desired information.

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