

**CCN**

**ADMINISTRATIVE MANUAL**

**For Participating Providers**

**January 2002**  
**Revised August 2006**

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**CCN  
ADMINISTRATIVE PROCEDURES**

**P-1 DEFINITIONS**

- 1.01** Terms used in this Administrative Manual are defined in the CCN Professional Care Provider Agreement, Section 1, Definitions. Additional terms are defined in Sections P-1.02 through P-1.06 and U-2.02 through U-2.10 of this Manual.
- 1.02** "Utilization Review" means the function performed by organization(s) or entity(ies) selected by Payors to review and recommend to Payors whether Health Care Services or Benefits provided, or to be provided, are Medically Necessary.
- 1.03** "Medically Necessary" means services or supplies which are determined to be:
- (a) Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition,
  - (b) Provided for the diagnosis or direct care and treatment of the medical condition,
  - (c) Within standards of good medical practice within the organized medical community,
  - (d) Not primarily for the convenience of the Beneficiary or Claimant, the Beneficiary's or Claimant's Provider or another provider, and
  - (e) The most appropriate supply or level of service which can be safely provided. For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Beneficiary or Claimant is receiving or the severity of the Beneficiary's or Claimant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.
- 1.04** "Emergency" means the sudden onset of a medical condition manifest by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:
- (a) Permanently placing the Beneficiary's or Claimant's health in jeopardy,
  - (b) Causing other serious medical consequences,
  - (c) Causing serious impairment to bodily functions, or
  - (d) Causing serious and permanent dysfunction of any bodily organ or part.
- 1.05** "Provider" means a validly licensed Provider who is contracting with CCN through a CCN Professional Care Provider Agreement.
- 1.06** "Contract Facility" means a facility that has entered into an agreement with CCN to provide Health Care Services or Benefits to Beneficiaries or Claimants pursuant to Payor Agreements.

**P-2 COMPENSATION AND BILLING**

- 2.01** Provider shall seek payment from CCN Payors for the provision of Health Care Services or Benefits except as provided in Sections P-2.02, P-2.03, P-2.04, P-2.06, P-2.10 and P-2.11. The payment from Payors shall be limited to the Reimbursement Amounts referred to in Exhibit A of the CCN Professional Care Provider Agreement less co-payments and deductible amounts.
- 2.02** Provider shall, to the extent possible, seek, accept and maintain evidence of assignment for the payment of Health Care Services or Benefits provided to Beneficiaries or Claimants by Provider under the applicable Insuring Agreement. If a Beneficiary or Claimant refuses to provide such evidence of assignment, Provider may seek payment from the Beneficiary or Claimant directly. The charges shall be limited to the Reimbursement Amounts set forth in Exhibit A of the CCN Professional Care Provider Agreement.
- 2.03** Provider may also seek payment for the provision of Health Care Services or Benefits from other sources as provided in Section P-2.04, and as available pursuant to the coordination of benefit provisions of the applicable Insuring Agreement and Section P-2.05.
- 2.04** Provider agrees that the only charges for which a Beneficiary or Claimant is liable and can be billed by Provider shall be for Health Care Services or Benefits not covered by the applicable Insuring Agreement, for co-payments and deductible amounts required by the applicable Insuring Agreement, or as provided in Sections P-2.02, P-2.06, P-2.10 and P-2.11.

- 2.05** In a case in which the CCN Payor, under the applicable Insuring Agreement, is the primary Payor under applicable coordination of benefit rules, Payor shall pay the amounts due under the Reimbursement Amounts reduced as provided in Section P-2.01. In a case in which Payor is other than primary, Payor shall pay only those amounts which when added to amounts owed to Provider from other sources pursuant to the applicable coordination of benefit rules, equals one hundred percent (100%) of the amounts that Payor would have paid if primary.
- 2.06** Provider shall not collect payment for Health Care Services or Benefits determined to be not Medically Necessary by Review Organization, unless the Beneficiary or Claimant has agreed in writing, prior to delivery of the Health Care Services or Benefits, to be responsible for payment of those charges. That agreement may be obtained by Provider, on a form approved by CCN.
- 2.07** CCN may increase the Reimbursement Amounts as appropriate after so notifying Provider in writing. CCN will give Provider thirty (30) days prior written notice of any decrease in the Reimbursement Amounts.
- 2.08** Provider shall bill Payor in a manner acceptable to Payor within ninety (90) days of providing the Health Care Services or Benefits. Provider shall furnish, on request, all information reasonably requested by Payor to verify and substantiate the provision of Health Care Services or Benefits and the charges therefore. Payor may review all information submitted by Provider when necessary.
- 2.09** CCN Payor Agreements shall require that Payors pay Provider within thirty (30) calendar days of receipt of billings which are ready for processing, i.e., are accurate, complete (including coordination of benefits determinations and medical review if necessary) and otherwise in accordance with Section P-2.08 and P-2.12.
- 2.10** If the payment pattern for any Payor becomes more than thirty (30) calendar days, CCN shall, upon notification from Provider, notify the Payor that it is out of compliance with the CCN payment requirement and should take prompt remedial action. If the Payor continues to be out of compliance with the CCN payment requirement over the next two (2) months, CCN shall review the Payor Agreement with the expectation of termination. If the Payor Agreement is terminated for noncompliance with the CCN payment requirement, the Provider shall not be bound by Section 2.02 of the CCN Professional Care Provider Agreement and Section P-2.04 of this Manual with respect to Beneficiaries or Claimants of that Payor.
- 2.11** If a Payor becomes subject to a bankruptcy proceeding, the Provider shall not be bound by Section 2.02 of the CCN Professional Care Provider Agreement and Section P-2.01 of this Manual with respect to Beneficiaries or Claimants of that Payor.
- 2.12** The following specifications apply for the claim form used by a Provider's office to bill for professional services furnished to CCN Beneficiaries or Claimants:
- (a) To expedite prompt and accurate processing of claims, "CCN" should be noted on the top right corner of the claim form. (Unless CCN claims are properly identified, their processing may be delayed.)
  - (b) The claim shall include all of the following information:
    - Patient's Name
    - Patient's birthdate or age
    - Beneficiary's or Claimant's name
    - Patient's address
    - Patient's sex
    - Beneficiary's or Claimant's ID number (Social Security number or other identification number)
    - Relationship of patient to Beneficiary or Claimant
    - Beneficiary's insurance group number or Claimant's health plan code
    - Name of Payor and employer
    - Claimant's number (if work-related) (put in box 10A)
    - Information concerning other insurance coverage of patient
    - Date of injury (indicate if injury is work related or auto accident related)
    - Beneficiary's or Claimant's address
    - Information (and dates) if patient has had same or similar illness or injury

- Date patient able to return to work (if work related)
  - Referring Provider, if any
  - Place of service
  - Diagnosis (using ICD-9 codes)
  - Date of Service
  - Service or procedure codes (CPT codes where applicable)
  - Itemization of Provider's usual billed charges
  - Provider's name
  - Provider's license number
  - Provider group or clinic name if applicable
  - Provider or Provider's billing address (including zip code)
  - Provider's federal tax identification number (If Provider is a sole proprietor, the Social Security Number should be used. If Provider is incorporated or in legal partnership, the Provider's IRS Employer Identification Number should be used.)
- (c) If claims are submitted by way of electronic data entry, the information in (a) and (b) above shall be included in the entry.

**2.13** When an audit performed by a Payor or its designated agents discloses that the Provider has been overpaid under this Agreement, or where the total payments exceed the total liability under this Agreement, the Provider agrees that any such overpayment or excess payments over liability may be recouped by the Payor.

**2.14** Medical-Legal Reports (i.e., reports obtained at the request of the employee or employer to prove or disprove a contested claim) are outside the scope of the CCN Professional Care Provider Agreement.

### **P-3 MARKETING, ADVERTISING AND PUBLICITY**

**3.01** CCN and Payors shall have the right to use the name, specialty, office address(es) and telephone number(s) of Provider in the CCN Provider listings for purposes of informing Beneficiaries or Claimants and prospective Beneficiaries or Claimants of the identity of CCN Providers.

**3.02** Except as provided in Section P-3.01, CCN, Payors, and Provider each reserves the right to and the control of the use of its name and all symbols, trademarks or service marks presently existing or later established.

### **P-4 IDENTIFICATION OF CCN PAYORS AND BENEFICIARIES**

**4.01** In accordance with Section 6.03 of the CCN Professional Care Provider Agreement, CCN shall provide Provider with access to lists of all Payors, periodically, who have executed Payor Agreements with CCN to use the CCN Provider network.

**4.02** CCN will supply "CCN" stickers to group health Payors for use on Beneficiary health plan cards to assist Provider in identifying CCN Beneficiaries patients.

**4.03** Payor Agreements will require Payor or Payor's claims administrator to verify Beneficiary or Claimant eligibility if requested during normal business hours. CCN Payor listing sent to Provider will include the phone numbers to use for patient eligibility verification for each Payor.

## **P-5 REFERRALS TO CCN PROVIDERS**

- 5.01** CCN Providers shall comply with Section 5.07 and 5.08 of the CCN Professional Care Provider Agreement and admit Beneficiaries or Claimants to CCN Contract Hospitals and refer Beneficiaries or Claimants to CCN participating providers.
- 5.02** Non-compliance with Section P-5.01 and Section P-6 of this Administrative Manual may result in CCN evoking Section 3. Term; Termination, as specified in the CCN Professional Care Provider Agreement.

## **P-6 REFERRALS TO NON-CCN PROVIDERS**

- 6.01** A non-Emergency referral to a non-CCN Provider requires review and approval by CCN in order for the services to be reimbursed at the benefit levels for CCN participating providers under group health plans. CCN will authorize referral to a non-CCN Provider only if the services could not be provided by a CCN Provider in a manner consistent with the medical needs of the Beneficiary or Claimant.
- 6.02** When a CCN Provider needs to refer a Beneficiary or Claimant to a non-CCN Provider for specialized care because a CCN Provider is not available, the CCN Provider shall request authorization for the referral from CCN by completing a "Request to Refer to a Non-CCN Provider" form (Exhibit A to this Manual) and submitting it to CCN.
- 6.03** If the request is authorized, CCN will forward a copy of the completed "Request to Refer to a Non-CCN Provider" form to the non-CCN Provider. The non-CCN Provider shall attach the form to the claim(s) for services based on the referral in order that reimbursement shall be according to the benefit levels for CCN participating Providers specified under the applicable Insuring Agreement.
- 6.04** It is expected that all non-Emergency admissions will be to Contract Facilities. However, there may be circumstances requiring certain specialized care which could result in a scheduled admission to a non-Contract Facility. Should this occur, the admitting Provider should first call the designated Review Organization to initiate Utilization Review.
- 6.05** In case of an Emergency, as that term is defined in Section P-1.04, the Provider should use a Contract Facility whenever possible and should inform the Review Organization of the admission.

## **P-7 REPLACEMENT PROVIDER OR ON-CALL COVERAGE**

- 7.01** Provider shall arrange for twenty-four (24) hour practice coverage so that Beneficiaries or Claimants may reach Provider or Provider's designated replacement during evenings and weekends. Provider shall exercise best efforts to designate a replacement who is a CCN participant or who agrees to abide by the terms of the CCN Professional Care Provider Agreement for Beneficiaries or Claimants as part of the coverage arrangement.
- 7.02** Replacement arises when a non-CCN Provider agrees to treat a CCN Provider's Beneficiary or Claimant as part of a coverage arrangement and accepts reimbursement for the professional services according to the terms of the CCN Professional Care Provider Agreement.
- 7.03** The replacement form (Exhibit B to this Manual) must be completed and signed by both Providers. The non-CCN Provider shall attach the replacement form to all claims submitted to Payor for payment while serving as a replacement or on-call Provider. Reimbursement to the non-CCN Provider shall be based upon the Reimbursement Amounts specified in the CCN Professional Care Provider Agreement.

## **P-8 LISTINGS OF CCN PROVIDERS**

- 8.01** CCN shall periodically send Provider a listing of all CCN Providers. Copies of the listings may also be available through the medical staff office of each contracting facility. Additionally, CCN shall maintain updated lists of CCN contracting providers for reference.
- 8.02** If a Provider changes his/her practice address, Provider shall notify CCN of the address change within five (5) days of such change.

## **P-9 UTILIZATION REVIEW AND QUALITY ASSURANCE**

- 9.01** Subject to all applicable laws relating to privacy and confidentiality requirements, Provider shall make available medical records of Beneficiaries or Claimants upon reasonable request to Payors, to each health care professional treating the Beneficiary or Claimant, and for Utilization Review purposes.
- 9.02** Provider shall cooperate with the CCN Utilization Review/Quality Assurance Program specified in Sections U-1 through U-7 of this Manual.

## **P-10 NOTIFICATION REQUIREMENTS**

- 10.01** Provider shall notify CCN within five (5) days of the occurrence of any of the following:
- (a) Any change in billing information supplied by Provider to CCN including office address and phone number, tax ID number, DEA registration, and group affiliation.
  - (b) Any legal action threatened or pending against the Provider for professional negligence which may reasonably be considered to be a material loss contingency, and the final disposition of the action.
  - (c) Any indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession or reimbursement for services provided.
  - (d) Any restriction, suspension, revocation or voluntary relinquishment of the Provider's medical staff membership or clinical privileges at any health care facility unless such action will last thirty (30) days or less.
  - (e) Any pending or threatened investigation, complaint or sanction proceeding against Provider related to the practice of Provider's profession or reimbursement for services provided.
- 10.02** Provider shall update information as requested on CCN Data Verification Forms and recredentialing information requests mailed periodically by CCN to Provider.

## **P-11 INSURANCE REQUIREMENTS**

- 11.01** Provider shall carry Professional Liability Insurance or equivalent program of self insurance in minimum amounts of one million dollars (\$1,000,000) for any one incident and three million dollars (\$3,000,000) annual aggregate; OR in minimum amounts per State regulations, whichever is less.
- 11.02** Provider shall also maintain policy or program of comprehensive liability insurance, covering Provider's acts or failure to act, with minimum coverage of not less than three hundred thousand dollars (\$300,000) for Provider's property, three hundred thousand dollars (\$300,000) per claim for bodily injury, together with a combined single limit bodily injury and/or property damage insurance coverage of not less than one million dollars (\$1,000,000); OR in minimum amounts per State regulation, whichever is less.

## **P-12 COMPEXCEL/COMPEXCEL PLUS PROGRAM**

- 12.01** CCN shall designate Primary Treating Providers (PTPs) for CCN's CompExcel/CompExcel Plus Managed Care Programs. PTPs shall be contracting Providers selected by CCN who are knowledgeable about and experienced in treating workers' compensation claimants, who agree in writing to CCN's requirements for PTPs as specified in Section P-13 and who are identified as PTPs by CCN.
- 12.02** CCN shall require in Payor Agreements that CompExcel/CompExcel Plus participating employers use best efforts to direct CompExcel/CompExcel Plus participating Claimants with work related accidents or injuries (herein referred to as CompExcel/CompExcel Plus Injured Workers) to PTPs for non-emergency care and notify CCN of work-related accidents and injuries of CompExcel/CompExcel Plus Injured Workers as soon as possible.
- 12.03** CompExcel/CompExcel Plus payors will select a PTP upon program implementation for each employer location.

- 12.04** CCN shall maintain a twenty-four (24) hour 800 number telephone line to assist CompExcel/CompExcel Plus Injured Workers, employers and emergency service staff in identifying PTPs, directing CompExcel/CompExcel Plus Injured Workers to PTPs for non-emergency care, and to assist PTPs in identifying other CCN participating providers for patient referrals as needed.
- 12.05** Non-emergency treatment of CompExcel/CompExcel Plus Injured Workers without PTP referral may not be payable by Payor and, Providers are prohibited by state law from billing patients for treatment of work-related accidents and injuries.
- 12.06** PTPs shall:
- (a) Be designated as a workers' compensation certified provider if required by the state. Make up to 5% of their full-time practice available as needed to treat injured workers participating in CompExcel/CompExcel Plus.
  - (b) Treat assigned CompExcel/CompExcel Plus Injured Workers within one (1) Working Day of request for non-urgent care and immediately for emergency care.
  - (c) Maintain average waiting times for treatment of fifteen (15) minutes or less for scheduled appointments.
  - (d) Transmit a copy of the Doctor's First Report of Occupational Injury or Illness for CompExcel/CompExcel Plus Injured Workers to CCN and to Payors within one (1) Working Day of treatment by fax or mail.
  - (e) When referring a CompExcel/CompExcel Plus Injured Worker for any service other than laboratory or x-ray (excluding CT Scans and MRI) direct within the CCN Network and contact CCN by 800 number telephone line.
  - (f) Insure that all referral appointments for CompExcel/CompExcel Plus Injured Workers are scheduled to occur within seventy-two (72) hours or notify CCN of delays in scheduling.
  - (g) Send all medical claims for services provided to CompExcel/CompExcel Plus Injured Worker along with the associated reports to CCN and include on claims the date of injury and Payor's claim file number, if assigned.
  - (h) If a CompExcel/CompExcel Plus Injured Worker requires more than three (3) office visits or more than three (3) days off of work, PTP shall contact CCN to coordinate clinical treatment and return to work plans.
  - (i) Provide necessary documentation for CCN to determine the medical necessity and appropriateness of the return to work and/or treatment plan.
- 12.07** Provider receiving a referral of a CompExcel/CompExcel Plus Injured Worker shall provide only those services requested. Provider shall maintain average waiting times for treatment of fifteen (15) minutes or less for scheduled appointments.
- 12.08** PTP shall ensure that after hour and on-call coverage is available for CompExcel/CompExcel Plus Injured Workers at all times and such care is provided by a CCN contracted Provider, clinic or hospital. If such arrangement is not possible, both providers must complete the Authorization for Replacement Provider Form (Exhibit B) and submit it with each medical claim for services provided to a CompExcel/CompExcel Plus Injured Worker.
- 12.09** PTP shall inform CCN of the name, address and phone number of PTP after hour on-call provider and arrange with the after hour provider to refer all follow-up care to the PTP.
- 12.10** CompExcel/CompExcel Plus Injured Workers are subject to the Utilization Review/Quality Assurance Procedures appearing in this Administrative Manual in Sections U-3 and U-5.
- 12.11** Except as specified in Section P-13 of the CCN Administrative Manual, all other terms and conditions of the CCN Professional Care Provider Agreement and the CCN Administrative Manual for Participating Providers shall apply for CompExcel/CompExcel Plus.

**CCN  
UTILIZATION REVIEW/QUALITY ASSURANCE PROGRAM**

**U-1 INTRODUCTION**

- 1.01** CCN shall establish Utilization Review/Quality Assurance Program to conduct Utilization Review of Health Care Services or Benefits for Beneficiaries or Claimants of CCN affiliated health plans. CCN or its designated affiliate or subsidiary (hereinafter "Review Organization") shall establish and maintain review procedures and screening criteria which are consistent with the prevailing standards for quality of medical care. The primary consideration of CCN, the Review Organization(s), and the participating providers shall be the quality of the health care services rendered to covered persons.
- 1.02** The Utilization Review process has two primary objectives:
- (a) To ensure that Health Care Services or Benefits provided to Beneficiaries or Claimants are Medically Necessary and are provided in the appropriate inpatient or outpatient setting; and
  - (b) To ensure that Health Care Services or Benefits meet local community standards for quality care as set by the Review Organization(s) and CCN, and are provided at the appropriate level of care.
- 1.03** CCN Payors shall consider recommendations made by the Review Organization(s) regarding Medical Necessity in determining payment of claims. Disapproval recommendations shall be subject to the appeal procedures provided in Section U-7. CCN Payors retain final responsibility for determining payment or non-payment of claims.

**U-2 DEFINITIONS**

- 2.01** Terms used in these procedures are defined in the Professional Care Provider Agreement, Section 1, Definitions or in the Administrative Manual for Participating Providers, Section P-1, Definitions. Additional terms used are defined in Sections U-2.02 through U-2.10 of these procedures.
- 2.02** "Review Organization" means an organization or entity selected by Payor to perform Utilization Review according to the CCN Utilization Review/Quality Assurance Program.
- 2.03** "Certification Form" means a document on which is stated the Review Organization's determinations regarding the Utilization Review performed on behalf of Payor.
- 2.04** "Review Coordinator" means a professionally qualified person who is competent to conduct initial review, data analysis and other functions involved in the Utilization Review.
- 2.05** "Physician Advisor" means a validly licensed physician who is utilized by a Review Organization to carry out Utilization Review.
- 2.06** "Norms" means numerical or statistical measures of observed performance of health care services derived from aggregated information related to the health care services provided to a statistically significant number of persons, as developed by the Review Organization.
- 2.07** "Screening Criteria" means those written guidelines adopted by the Review Organization pursuant to the Utilization Review functions described herein.
- 2.08** "Provider" means the provider who is responsible for the inpatient or outpatient care of the Beneficiary or Claimant.
- 2.09** "Working Day" means Monday through Friday from 8:00 a.m. to 4:30 p.m., excluding legal holidays.
- 2.10** "Medically Necessary" means services or supplies which are determined to be:
- (a) Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition;
  - (b) Provided for the diagnosis or direct care or treatment of the medical condition;

- (c) Within standards of good medical practice within the organized medical community;
- (d) Not primarily for the convenience of the Beneficiary or Claimant, the Beneficiary's or Claimant's Physician or another provider; and
- (e) The most appropriate supply or level of service which can be safely provided. For facility stays, this means that acute care as an inpatient is necessary due to the kind of services the Beneficiary or Claimant is receiving or the severity of the Beneficiary's or Claimant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

### **U-3 UTILIZATION REVIEW FUNCTIONS**

- 3.01** Utilization Review for Inpatient Services or Outpatient Services provided to Beneficiaries or Claimants shall be conducted in Contract Facility or by Provider as agreed to by Payor and shall include:
- (a) "Preadmission review" of all scheduled inpatient admissions to determine whether the admission is Medically Necessary.
  - (b) "Admission review" of all unscheduled inpatient admissions to determine within one (1) Working Day of admission whether the admission was Medically Necessary.
  - (c) "Concurrent review" performed periodically during all facility stays of Beneficiaries or Claimants to determine whether continued inpatient stay is Medically Necessary.
  - (d) "Retrospective review" of the Medical Necessity of facility stays when the patient was not identified to the Review Organization in a timely manner to permit admission review or when only retrospective review is available.
  - (e) "Preprocedure review" of all scheduled outpatient services to determine if they are Medically Necessary.
  - (f) "Physical medicine review" of outpatient physical therapy services. The physical medicine review program requires Provider to pre-certify physical therapy treatment plans exceeding five (5) visits as Medically Necessary.
- 3.02** Review Organization may review claims for services to verify accurate and complete billing and may, from time to time, perform Utilization Review of claims to determine whether services provided were Medically Necessary. Services preauthorized through the CCN Utilization Review/Quality Assurance Program, including but not limited to, Preadmission review, Admission review, Concurrent review, Preprocedure review or Physical Medicine review will not be subject to retrospective denial for Medical Necessity.

### **U-4 RESPONSIBILITIES OF THE REVIEW ORGANIZATION**

- 4.01** The Review Organization shall develop, update, and maintain Screening Criteria which shall be subject to the review and approval of CCN.
- (a) Screening Criteria shall be developed for the purpose of making a determination of whether an inpatient facility admission, continued inpatient facility stay or outpatient services are Medically Necessary.
  - (b) Screening Criteria shall be based on professional expertise, current professional literature, and cumulative information on health care services provided within the community to a statistically significant number of persons.
  - (c) Screening Criteria shall be developed to enable the Review Coordinator to select for review by the Physician Advisor only those cases which appear not to fall within local community standards as established by the Review Organization and CCN.
- 4.02** Review Organization shall utilize professionally qualified review personnel to perform the duties of Review Coordinators. Such Review Coordinators shall have authority to use the Screening Criteria to provide recommendations for approval of Beneficiaries' or Claimants' inpatient facility admissions and continuing inpatient stays or outpatient services. A Review Coordinator shall have no authority to disapprove an inpatient facility admission, inpatient stay or outpatient services.

- 4.03** Recommendations of disapproval by the Review Organization shall be made only by a Physician Advisor, after a review by the Physician Advisor of information contained in the Beneficiary's or Claimant's medical record and after consultation with the Provider. If the Provider is unavailable for consultation with the Physician Advisor and available information is insufficient for recommendation of the inpatient facility admission or continued inpatient facility stay or outpatient services, the Physician Advisor may not recommend the admission, stay or outpatient services subject to reconsideration and other appeal as provided in Section U-7.
- 4.04** The Review Organization shall respond to requests for preadmission review and preprocedure review by providing its review recommendations and a reference number to the Provider by telephone within one (1) Working Day of receipt of all relevant clinical information. Review Organization shall respond to requests for physical medicine review by telephone within one (1) Working Day of such request.
- 4.05** If denial is recommended as a result of the findings from preadmission review, Preprocedure review or physical medicine review, the Review Organization shall provide written notification to the Provider, Contract Facility, and Beneficiary or Claimant within two (2) Working Days of the request.
- 4.06** The Review Organization shall respond to requests for reconsideration of Preadmission review, Preprocedure review, or Physical Medicine review findings by making a redetermination and communicating the results to the Provider (or to the treating provider for physical medicine review) by telephone within one (1) Working Day of the request of receipt of all relevant clinical information and in writing to the Provider, Contract Facility, and Beneficiary or Claimant within two (2) Working Days of the request. Further appeal shall be conducted, if requested, according to the appeal procedures provided in Section U-7 below.
- 4.07** The Review Coordinator shall use the Screening Criteria to conduct Concurrent review periodically for approved inpatient facility stays to determine the continued Medical Necessity of the stay. This process shall continue until the Beneficiary or Claimant is discharged.
- 4.08** If the Physician Advisor determines, on the basis of available information obtained from the Beneficiary's or Claimant's medical record and the attending Provider, that a continued inpatient facility stay is not Medically Necessary, the Review Organization shall immediately issue written notification to the attending Provider. Such notification shall include an explanation of the procedure for requesting reconsideration. In such cases, the Review Organization shall also notify Contract Facility, and Beneficiary or Claimant in writing, and facility services provided to the Beneficiary or Claimant before midnight of such notification day will be considered Medically Necessary.
- 4.09** If reconsideration of such determination is requested, the Review Organization shall reconsider the decision and communicate it to Contract Facility, Provider, and Beneficiary or Claimant in writing, no more than two (2) Working Days after the request if the Beneficiary or Claimant is an inpatient. Otherwise, the Review Organization shall notify Contract Facility, Provider, and Beneficiary or Claimant or in writing, within twenty (20) Working Days of the request. Further appeal shall be conducted, if requested, according to the appeal procedures provided in Section U-7 below.
- 4.10** For Claimants under workers' compensation plans, the Review Organization will provide notices of recommended disapprovals of admission or continued stay exclusively to Contract Facility, Provider, and the Plan Representative.
- 4.11** In making any determination regarding whether an inpatient facility admission, continued inpatient facility stay, or outpatient services are Medically Necessary, the Review Organization shall consider all available relevant information. The Review Organization shall thoroughly document its actions and the rationale for its determinations. The Review Organization shall provide a Certification Form to Contract Facility for each inpatient stay.

## **U-5 UTILIZATION REVIEW PROCESS**

- 5.01** To avoid potential disapproval of payment for Inpatient Services or Outpatient Services provided to Beneficiaries or Claimants, the Provider shall be encouraged to request Preadmission or Preprocedure review from the Review Organization at least two (2) Working Days prior to all scheduled inpatient admissions, five (5) or more physical medicine visits, or the provision of the outpatient services.
- 5.02** At the time of request for review, Provider shall provide the following information:
- (a) Patient's name and social security number,
  - (b) Patient's age and sex,
  - (c) Beneficiary's or Claimant's name and social security number,
  - (d) Primary and secondary diagnoses,
  - (e) Reason for admission (if preadmission review),
  - (f) Scheduled date of admission or Outpatient Services,
  - (g) Planned primary and secondary procedure or surgery,
  - (h) Date of planned procedure or surgery,
  - (i) Name of facility to which Beneficiary or Claimant will be admitted or will receive Outpatient Services,
  - (j) Name and telephone number of Provider,
  - (k) Other information as may be requested by the Review Organization.
- 5.03** All scheduled admissions for procedures or surgeries shall be morning admissions. Any exception (admission the night before a surgery or procedure) must be reviewed and approved by the Review Organization based on Medical Necessity as determined by the Review Organization.
- 5.04** If Provider has not received notice of a preadmission or preprocedure determination as required by Utilization Review/Quality Assurance Program at the time of a scheduled admission or outpatient service, it shall contact the Review Organization to request the determination. Any admission that requires Preadmission review or outpatient service which require Preprocedure review, including Physical Medicine review, which has not received that review may be subject to retrospective disapproval.
- 5.05** To initiate admission review, Provider shall notify the Review Organization of the admission at the time the Beneficiary is admitted. If a Beneficiary or Claimant is admitted on other than a Working Day, Provider shall notify the Review Organization of the admission during the morning of the next Working Day following the admission.
- 5.06** Review Organization shall inform the Provider requesting scheduled admission or outpatient services at non-contracted facility that Beneficiary or Claimant participates in a preferred facility system. Review Organization will identify Contract Facilities in the area for the Provider.
- 5.07** The Review Organization shall inform CCN within one (1) Working Day after it is notified of any admission or scheduled outpatient service including physical medicine services of a Beneficiary or Claimant at a non-contracted facility. CCN will inform Payor of such services so that Payor may advise Beneficiary or Claimant of his/her benefits related to such services.

## **U-6 UTILIZATION REVIEW AND PAYMENT OF CLAIMS**

- 6.01** If the Review Organization conducts review on-site, a Certification Form with the review determination from the designated Review Organization is a required attachment to all inpatient claims submitted by Contract Facility for processing. Such attachment is not required if the review was done telephonically. Arbitration shall be commenced by Contract Facility or Provider making written demand on CCN.
- 6.02** Claims may be subject to retrospective denial of payment by the Payor if the required Utilization Review approvals have not been obtained or when only retrospective review is available.

- 6.03** Claims received without required Utilization Review approval will be returned to Provider.
- 6.04** Provider submitting claims by way of electronic data interchange shall indicate, in the appropriate space on the screen, that the services which require Review Organization approval have been approved. Payors will reject claims without that indication.
- 6.05** Provider shall furnish Review Organization with a copy of the UB-92 or HCFA 1500 upon request.
- 6.06** The Utilization Review decisions made by the Review Organization are solely for determining whether facility services and medical services are Medically Necessary. Claims processing and payment determination shall be the sole responsibility of the Payor.

#### **U-7 APPEAL AND ARBITRATION OF UTILIZATION REVIEW DECISIONS**

- 7.01** Contract Facility, Provider, Beneficiary or Claimant may appeal a Utilization Review decision. The appeal shall be commenced by requesting reconsideration by the CCN Review Organization making the initial decision. Requests shall be made in writing within sixty (60) days of the review decision and must give the reasons why it is believed that services were Medically Necessary. Provider or Contract Facility shall provide a copy of the applicable medical records to the Review Organization upon request at no cost to Review Organization or Payor.
- 7.02** If the Beneficiary or Claimant is still hospitalized, and a reconsideration has been requested, the Review Organization shall notify Contract Facility, Provider, and Beneficiary or Claimant of the decision in writing within no more than two (2) Working Days of the request.
- 7.03** If the Beneficiary or Claimant has been discharged, the Review Organization shall provide written notification of the reconsideration decision. This notification shall be sent to the Facility, Provider, and Beneficiary or Claimant and will be made within twenty (20) days of the request.
- 7.04** If the Facility or Provider is not satisfied with the result of the appeal to the Review Organization, it may request a review by the CCN Medical Director. If the party filing the appeal continues not to be satisfied, it may request binding arbitration as provided in Section 12 of the Professional Care Provider Agreement.
- 7.05** The arbitration shall be commenced by Contract Facility or Provider making written demand on CCN. The scope of the arbitration shall be limited to a determination of whether, or to what extent, services provided were Medically Necessary.



**CCN  
ADMINISTRATIVE MANUAL: EXHIBIT B**

**AUTHORIZATION FOR REPLACEMENT PROVIDER OR ON-CALL COVERAGE**

**CCN PROVIDER:** \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

\_\_\_\_\_  
(License Number) Signature of CCN Provider

**NON-CCN PROVIDER:** \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

\_\_\_\_\_  
(License Number) (Federal Tax ID Number)

**Patient Name:** \_\_\_\_\_

I certify that I am treating this patient in place of the CCN Provider named above because of the temporary unavailability of that Provider. For all claims submitted for services I provided to this Beneficiary or Claimant, I agree to be bound by the terms of the CCN Professional Care Provider Agreement. I understand that thereby I accept payment according to the CCN contracted Reimbursement Amounts as payment in full for my services (including deductibles and co-payments that I may collect under the applicable Insuring Agreement), that I abide by Utilization Review decisions, and that I accept assignment of benefits and file claims on the patient's behalf. I will review the CCN Professional Care Provider Agreement in possession of the CCN Provider named above so that I may be fully familiar with its terms.

**SIGNED:** \_\_\_\_\_  
(Non-CCN Provider) (Date)

**NOTE:** This form should be attached to all claims submitted by the non-CCN Provider for services provided to the Beneficiary or Claimant, in order that reimbursement can be according to the benefit levels for CCN Providers