NetCare
Life & Health Insurance

Participating Provider Manual

Issued by
NetCare Life & Health Insurance Company
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Preface

NetCare Life & Health Insurance Company has attempted to ensure the information in this manual is current and accurate, but does not warrant that the information is completely error-free.

This manual is meant to provide general information only and may not contain complete or specific information on a given topic.

The participating provider is encouraged to contact NetCare's Provider Relations Department for explanation or clarification when necessary. The policies and procedures referenced in this manual may change without prior notice, and the provisions of other organizing documents supersede any contrary information contained in this manual. NetCare will make every attempt, however to provide you with prior notice of any policy and procedural changes as required.

Please contact our Provider Relations Department for explanations or clarification as necessary.

About NetCare Life & Health

NetCare Life & Health Insurance Company is a Guam based domestic life and health insurance carrier. NetCare received its Certificate of Authority from the Insurance Commissioner of Guam in 1998.

Today, NetCare generates over $30 million dollars in annualized premium revenues and insures over 20,000 members covering over 300 employer groups in its group life, individual life, group health and Third Party Administration (TPA) programs on Guam, CNMI, FSM and Palau. NetCare utilizes a Preferred Provider Organization (PPO) and Point of Service (POS) model to deliver quality health care services to clients.

NetCare reinsures its life and health products with ING Re and Allianz Re. NetCare is administered and owed by Moylan's Insurance, Inc., a multi-line insurance agency with over 35 years of trusted service throughout Guam and Micronesia.

As a health insurance PPO carrier, NetCare provides access without a referral to quality medical care through its' participating provider network on Guam, Hawaii, CNMI, Asia and the United States Mainland. As a participating provider either under the PPO or POS Plans, you may also refer patients through NetCare's participating provider network. NetCare's team of customer service representatives as well as medical management specialists will work with your office to provide you information and access to any of these participating providers.

We pride ourselves in our customer service standards. Our commitment is to offer our customers and providers with responsive, quality and unsurpassed service.

Introduction and Welcome

Dear Participating Provider:

In an effort to improve and maintain good working relationships with participating providers and their medical staff, NetCare has prepared this manual to better assist you in the daily operations of serving patients who are NetCare members. As a participating provider, you play a very important role in the delivery of healthcare services to our members.

This manual is intended to serve as a guideline in addressing the administrative, operational, billing and coding issues and requirements concerning the delivery and payment of health care services.

Periodically, we will provide your office with any updates, changes and revisions to the manual and to our benefit policies.

We hope this manual and the information provided herein will help you better understand how NetCare operates. Please be sure to notify our offices in writing of any changes to your office hours, address, deletion or addition of new providers (group practice/associates). This will assist us in better maintaining information about you that will be easily communicated to our members.

We welcome any comments or suggestions you may have that will assist us in serving your needs more efficiently and timely.

Please feel free to contact our Provider Relations Department at 472-3610/14 if you should have any questions or need further information.

Sincerely,

Jerry Crisostomo
Jerry Crisostomo, MHP
Plan Administrator

Information on PPO

The fastest growing concept for providing quality health care while containing costs is a Preferred Provider Organization or 'PPO'. A PPO manages health care, weaving providers, purchasers and patients into an efficient network, with incentives for all to hold down expenditures.

PPO's are competitive alternative delivery systems designed to maintain the quality of health care while containing health care costs. It is an entity through which a partnership is established between a group of preferred providers – doctors, hospitals, and ancillary providers – and an insurance carrier to provide specified medical and hospital care at negotiated rates.

NetCare utilizes a PPO model arrangement designed to bring hospitals, physicians and medical specialists together under an organized network to facilitate arrangements between health care providers and group purchasers of health care services and benefits.

PPO's are developed to both help contain health care costs for employers as well as to provide a sustained market share for providers involved. PPO's also provide and utilize managed care concepts such as utilization review and data to control costs and improve the quality of health care. NetCare promotes a system in which the employer, the consumer and the providers all take part in containing cost and controlling the quality of health care services.

Some of the special 'hallmarks' of a PPO are:

- A PPO retains the concept of a fee-for-service medicine. Each physician, hospital or other health care provider who joins the PPO network bills for his/her services according to the negotiated fee schedule established in the written provider agreement.

- Freedom of choice of physicians and hospitals is retained in a PPO plan. Patients enrolled in a PPO plan may use the 'preferred providers' or go outside of the network for care. However, there are strong financial incentives that motivate patients to use the enrolled preferred providers.

- Preferred providers render their services at pre-agreed prices or rates-usually discounted from their usual and customary charges.

- Preferred providers accept strict management controls, such as utilization review, discharge planning and other techniques (i.e. Disease Management and Case Management) designed to contain costs. At the same time, quality controls are maintained to balance cost constraints with appropriate care.

- PPO's provide efficient claims payment systems as well as comprehensive data systems that enable buyers to track utilization patterns and medical costs.

Making NetCare Work Easy For You

Listed below are helpful and simple procedures that should make your work easier when dealing with NetCare members:

1. When patients check-in at the front desk, ask them to present their member identification card for eligibility purposes.

2. All NetCare members will have a member identification card or if a member is relatively new (within less than one month), an enrollment form will be presented. The NetCare member identification card will have the NetCare logo printed in the front of the card.

3. The member identification card will identify the employee and dependent(s) name, the member identification number and the Benefit Plan Type.

4. Eligibility and benefit coverage information are handled through our customer service help-line at 472-3610.

5. Claims inquiries and benefit utilization review matters are handled through our Medical Management department at 472-3610.

6. To verify eligibility, you may dial in through our on-line auto eligibility verification program administered by Decision Systems or you may also log into NetCare's web-site at www.netcarelifeandhealth.com and go to the provider portal for eligibility verification and benefits information. Contact our customer service department at 472-3610/14 for detail information and instructions.

7. Pre-Certification or prior authorization is required for certain outpatient and elective surgery (please refer to NetCare's listing of surgical procedures that require prior approval), home health care, skilled nursing, durable medical equipment, major diagnostic procedures (MRI, CT-Scan, ultrasounds). Refer to the section pertaining to Pre-Certification policies of this manual for more details on the Pre-Certification policy.

8. As a NetCare participating provider, you accept assignment of benefits, completing the billing process for patients, and you have agreed to participate in NetCare's utilization review process as well as retrospective review for audit purposes.

9. NetCare patients should **NOT** be asked for payment up front **UNLESS** their group's plan has an office visit co-payment and/or deductible amount which should be collected at the time of service. Refer to the section pertaining to Benefit Plans for further details on co-payments.

10. The patient should also **NOT** be balanced billed for any amount other than what is indicated in the Explanation of Benefits (EOB) and Provider Payment Transmittal Report.

11. NetCare requires the usage of the HCFA 1500 Claim Form for filing outpatient claims. Please be sure to clearly mark "NetCare"(or "NetCare/FSM" if applicable) on the front of the claim form. You will need to complete all information requested on the claim form as well as attach a copy of the clinical record or progress note (applicable to Evaluation and Management level III through level V) with the claim.

12. Send your claims for processing and payment to our claims management department. Claims must be submitted within ninety (90) days from the date of service. Claims submitted beyond 90 days from the date of service is not payable by either NetCare or the patient.

13. **COMMUNICATIONS IS ESSENTIAL**! Please make sure that everyone on your staff is aware of NetCare's policies and procedures. Please call us if you have any questions or need clarification.

Section 1: Member Identification Card

Section 1.1 Issuance of Identification Card

NetCare provides member identification cards for each employee and dependent(s) enrolled for coverage. This card is the primary mechanism identifying the individual as a NetCare eligible member.

The member identification cards are issued within two (2) weeks from the effective date of coverage to each employee and dependents. NetCare also issues a Verification Eligibility letter to the provider until a permanent card is issued. An employee can also use their copy of the enrollment application form as a source of identification.

Section 1.2 Member Identification Card Information

Presentation of the member identification card will identify a member to the respective provider. This will lend quick access to pertinent information regarding the member's benefit coverage. This information is necessary in coordinating admission and filing of claims for final billing to NetCare.

The attached member identification card will provide you with an example of how the identification card looks like. The member identification card contains the following information on the card:

- **Name of Member**: The name of the member for which services are provided
- **Member Identification Number**: The NetCare ID number of the member for which services are provided.
- **Benefit Plan Type**: The medical plan that the member is enrolled under.

The magnetic stripe located on the back side of the ID Card contains additional information once it is swiped using the verifone machine:

- **Effective Date of Coverage**: The date the member's coverage came into effect.
- **Carrier Number for Pharmacy**: The number assigned to *NMHC Rx.*
- **Co-Payments for**: This is the co-pay amount which should be collected when services are rendered.
  - -Office Visit
  - -Generic Drug
  - -Brand Drug

- **Coverage Type**: Identifies the coverage type such as ***medical, dental*** and ***vision*** that the member is enrolled under.
- **Plan Limitations**

Section 2: Eligibility Verification

There are three ways to verify member eligibility with NetCare: ***(1) Auto-Eligibility Verifone; (2) Customer Serivce Hotline; (3) Website Eligibility Program.***

Section 2.1 Auto Eligibility Verification

NetCare has outsourced its eligibility verification to Decision Systems As a provider, you have access to dial in your eligibility verification using the NetCare Verifone machine.

The Verifone eligibility program will provide you with the following member information:

1. Name of member
2. Member Identification Number
3. Benefit Plan Type
4. Applicable Co-Payments
5. Effective Date of Coverage

To dial or have access to the MCB MediComm Verifone system, you will need to receive prior approval from NetCare based on the volume of NetCare patients you have on a monthly basis.

To dial in using the Verifone System:

1. Press # on the Verifone machine. The number 1 identifies NetCare and directs all inquiry into NetCare's file record.
2. Enter the member identification number listed on the I.D. card, which consist of an eleven (11) digit number. You do this by manually pressing the numbered keypad on the Verifone machine.
3. Press ENTER once you have completed entering the member I.D. number.

The Verifone machine then dials automatically into a database which stores NetCare's eligibility file and prints out the eligibility information and status of the member.

Once you have obtained a hard copy print out, this completes the steps and procedures in utilizing MCB MediComm's Verifone System.

Section 2.2. Direct Eligibility Verification

As a participating provider, you may also contact NetCare's customer service department for direct verification of eligibility by calling (671) 472-3610/14 Monday thru Friday from 8:00 am to 5:00pm.

If you have appointments scheduled for the weekend or weekday evenings (after 5:00 pm), then you may contact our customer service department during the weekday for eligibility verification prior to the scheduled appointment on the weekend or weekday evenings.

Section 2.3 Website On-Line Eligibility Verification

You may also use the internet to dial into NetCare's website at www.netcarelifeandhealth.com and log into the Provider Portal to verify member eligibility, including benefit coverage, co-payments, limitations and exclusions. This service is available to you 24 hours a day.

PLEASE NOTE THAT NETCARE NO LONGER PROVIDES HARD COPY ELIGIBILITY LISTINGS DUE TO HIPAA PRIVACY POLICY.

Section 3: Claims Submittal

Section 3.1 Claiming Benefits for Services Rendered

The provider of service controls the submission of charges to NetCare for benefit payment. NetCare requires the usage of the Standard HCFA 1500 Claim Form for submission of outpatient medical charges (see attached form) or a hospital and facilities UB 92 claim form for inpatient medical charges. NetCare does not supply HCFA 1500 or UB 92 claim forms. These forms are the provider's responsibility to obtain.

The claim should indicate your full billed charges, although payment will be based on your specific contracted rate. Make sure you indicate the member's payment on the "amount paid" field of the HCFA 1500 claim form, or on the "prior payments" field of the UB 92 claim form. If your method of reimbursement is fee-for-service, NetCare reimburses your office the agreed upon contractual rate less any co-payments due from the member.

As a participating provider, you are required by local law to submit claims to NetCare within ninety (90) days from the date of service provided. Claims not submitted within this timeframe will be ***denied*** and you are not allowed to bill NetCare or the member pursuant to Guam law. You may submit claims daily or at least weekly to NetCare at the following mailing address or preferably via electronic transmission to NetCare's clearinghouse vendor (see Section 3.9 of this Chapter):

Claims Management Department
NetCare Life & Health Insurance Company
424 West O'Brien Drive, Suite 105
Julale Center
Hagatna, Guam 96910

NetCare will review for appropriateness all original claims delayed over one year from the month of service due to court decisions, administrative errors in determining a member's eligibility, reversal of decisions on appealed authorizations, and/or other circumstances beyond a provider's control. Claims submitted that are past the filing date limit must include the cause of delay or court order where applicable.

To assure prompt payment of the patient's claim, the following information must be on the claim form submitted for payment:

- Coverage Information
- Patient Information
- Physician Information
- ICD-9 and CPT codes as well as applicable modifiers
- Supplemental Information (e.g. Nature of Injury for possible Worker's Compensation claim; Motor Vehicular Accident information for possible Third Party Liability).

These items are essential for prompt payment. Incomplete or missing information on the claim form submitted for payment may result in additional delays in payment of benefits or denial of the claim.

Section 3.2 Billing, Coding and Documentations of Claims

In compliance with the 1997 Evaluation and Management National Guidelines and in order to improve the validation of the intended code selection; quality of medical record documentation and claims processing and payment, NetCare requires the following policies and procedures:

1. You will need to establish medical necessity through proper ICD-9 and CPT Codes.

2. NetCare requires that all claims submitted be coded to the ultimate level of specificity and in correct sequencing of ICD-9 Codes.

3. All clinical notes and medical records must be complete and ***legible*** to support proper usage of ICD-9 and CPT modifiers. Clinical notes and back-up records that are difficult to read may be denied for payment.

4. NetCare requires the submission of all necessary documentation to support higher levels of acuity, including new patient or established patient and consults, such as levels III through V.

5. All codes which are noted as having both professional and technical components for the procedure must be billed with appropriate modifier to note the service rendered by the provider.

6. If both components are rendered by a single provider, then the global modifier must be billed.

PLEASE NOTE: CORRECT AND ACCURATE CODING AND ICD SEQUENTIAL IS A MUST IN ORDER TO AVOID REJECTION OF CLAIMS BEING TRANSMITTED ELECTRONICALLY.

Section 3.3 Coverage Information:

- Employer or Group Name, patient or subscriber
- Group or Policy Number
- Subscriber's Social Security Number
- Have the employee or spouse sign a Consent Authorization Form that authorizes NetCare to pay benefits directly to the provider. NetCare accepts the message, which is the "signature on file" on the physician statement as an assignment of benefits.

Section 3.4 Patient Information:

- Patient's Name
- Patient's Date of Birth
- Patient's Sex
- Patient's Relationship to Subscriber
- Patient's Place of Employment
- Name of other Insurance Company or Payer, if applicable
- Address of other Insurance Company or Payer, if applicable

Section 3.5 Physician Information:

- Patient's diagnosis or symptoms, ICD-9 Coding, including a written description.
- Date the patient was first seen for diagnosis or condition treated.
- Description of service(s) to patient, using the CPT Coding.
- Date patient received service(s).
- Charge amount for each service or treatment received. Do not deduct or subtract any co-payments, the charge should reflect the actual fee for service.
- Patient Account Number (if available)
- Employer Tax Identification Number (EIN) of individual Social Security Number of attending physician.
- Name and address of the attending physician.
- Signature of attending physician.

Section 3.6 Supplementary Information:

- If the patient's condition or injury was due to an accident, include details of the accident.
- If the patient's condition or injury is related to the patient's occupation, indicate this on your statement (NetCare does not cover work related injuries).
- If surgery was performed and the procedure is not listed in the CPT Code, attach a copy of the operative report.
- If surgery was performed and procedure was complicated or took more time than usual, attach a copy of the operative report.

Section 3.7 Request for Medical Information

NetCare reserves the right to obtain and request medical information on members who have signed a Consent Authorization Form for release of such information. Providers are asked to cooperate with our Medical Management Department that request medical information and documents for the purpose of determining eligibility and for ease in processing a claim. NetCare will provide at least forty eight (48) hour written notice for such information.

Section 3.8 Denial of a Claim

An Explanation of Benefits (EOB) and a letter will be attached to a claim that has been processed and denied for payment. This will be sent to both the provider of service and the member. The member will then be financially responsible for satisfying the outstanding payment to the provider.

Section 3.9 Electronic Submission of Claims

NetCare is now accepting medical claims submission through our clearinghouse provider, Interactive Payer Network (IPN**). Please use payer I.D. number 66055** if you will be submitting claims electronically through IPN. This method can promote faster and more accurate claims processing and payment and is preferred to submitting paper claims. Contact NetCare's Systems Departmentat 472-3610 for more information on the required files specifications and layout for electronic submission.

Please be aware that once you are able to submit claims electronically, NetCare will not accept any manual claims from you should your claims be rejected electronically due to coding or sequencing errors etc… You will be required to

make the proper adjustments and corrections on the rejected claims and re-submit electronically.

Section 3.10 Resubmissions and Inquiries of Claims

The following procedures have been established for claims resubmissions and inquiries:

1. Resubmit claims or Request Status of claims **only after it is at least forty five (45) days from the date of submission to NetCare. This approach will avoid unnecessary system entry of duplicated claims as well as foregoing unwanted claim reconciliation.**

2. Copy your Explanation of Payment (EOP) or Provider Payment Transmittal Report to resubmit a Denied claims with notation of correction or questions on the copy. Highlight on the EOP copy the following:

   a) The claim number
   b) The Member's Name and NetCare I.D. number
   c) The Date Of Service (DOS)
   d) If additional information is required (i.e. proof of timely filing authenticated receipt of claims by NetCare bearing the member's signature or other insurance EOP for dual coverage.)

3. If you have not received payment and an Explanation of Payment for a claim, after 45 days, then you may resubmit a HFCA 1500 claim form again. Please be sure to record at the top of the claim for: "RESUBMISSION OR TRACER". You may also contact our customer service department to check the status of a claim.

4. **Do not mix "new" Date of Service with previously submitted Dates of Service.** New Dates of Service should be submitted as a new claim; not as a resubmittal claim.

Section 3.11 Claims Processing Overview

All claims received are sorted, date stamped, eligibility verified and entered into the claims processing system within two (2) business days of receipt from provider.

Claims received and entered into the system will be processed for payment or denied based on the date received order. To be eligible for payment, the claim must be clean and complete in all aspects such as:

- Complete coding or full written description of services
- Itemization of all services
- Complete dates of services
- Billed amount diagnosis code or written description
- Amount paid by member

Uncontested or clean claims are processed within 30 calendar days of the date of receipt to ensure that payment or denial notice is received by the 45th day.

Section 4: Reimbursement of Fees

Section 4.1 Reimbursement of Professional Fees

As a participating provider, you agree to accept reimbursement of professional fees for medical services rendered to a member directly from NetCare. Furthermore, as a participating provider, you also agree to accept or collect any professional fees over the office visit co-payment amount, until payment information is received through an Explanation of Benefits (EOB) or the Provider Payment Transmittal Report.

Therefore, submission of charges to NetCare for a covered member should be accomplished in a timely manner (within 90 days from date of service). For better understanding of how provider reimbursement of physician fees are calculated and paid, the following topics are discussed for your reference:

- Professional Fees
- Assignment of Benefits
- Office Visit Co-Payments
- Coordination of Benefits
- Secondary Payer and Benefits Payable

Section 4.2 Professional Fees:

NetCare utilizes fee surveys, industry charge analysis and other reimbursement methods to establish a pre-determined value or fee schedule of professional fees for participating providers. The intent of the fee schedule is to achieve a balance between fair physician reimbursement and effective cost containment. The pre-determined value for professional fees is a flat dollar amount assigned to each procedure listed in the Current Procedure Terminology (CPT) coding manual.

Compensation is on a pre-agreed fee-for-service basis. Providers receive a schedule of fees for the most commonly used procedure codes with their Provider Service Agreement. For procedure codes without specified rates, payments will be based on a percentage of the submitted charge or based on the average procedure cost that is experienced-rated. When multiple surgical procedures are to be performed, the provider should verify benefit coverage with NetCare for each procedure and receive a pre-certification authorization.

NetCare has adopted the Medicare Fee Schedule plus any appropriate adjustments as a standard reimbursement for services rendered by participating providers.

Section 4.3 Assignment of Benefits:

It is extremely important that the member completes an assignment of benefits. This assignment directs NetCare to pay any plan benefits directly to the physician. NetCare will honor and accept the message "signature on file" as an assignment of benefits. In the event a claim is received without an assignment or signature on file message, NetCare will issue payment to the physician and request the physician's office personnel to reimburse the member for any amount collected by the physician that exceeded the fee schedule, or the remaining balance of the patient's account.

Section 4.4 Office Visit Co-Payment:

An office visit is designed to encourage the member to seek medical care and attention for routine examinations or immunizations or at the first sign of illness before the condition becomes serious.

The co-payment is usually a flat dollar amount that the member pays at the time medical care is rendered in the provider's facility. It is the provider's responsibility to collect the applicable office visit co-payment from the member.

To determine the amount of co-payment due, you may refer to the Medical Plan Benefit section of this manual for more details. The appropriate office visit co-payment amounts appear on the front of the member's I.D. card.

The following services/encounters require a co-payment that should be collected at the time of service:

- Office Visit
- X-Ray Services
- Diagnostic Testing Procedures
- Laboratory

NetCare will issue an Explanation of Payment or Provider Payment Transmittal Report to the provider attached with the check payment. The Provider Payment Transmittal Report will indicate the amount of deductible or co-insurance or non-covered charges due from the member for submitted expenses. Charges for all services or treatment performed in the physician's office should be submitted to NetCare. Once the claims management department completes the review and

processing of the submitted expenses, the provider will bill the member for any deductible or co-insurance for the non-covered amounts.

Section 4.5 Coordination of Benefits:

Occasionally, a covered member will have group health benefits available from more than one employer or health plan. Please note that if this occurs and a member has an office visit co-payment, it should NOT be collected at the time of the visit. Benefits from both health plans will usually pay 100% of covered expenses.

Typically, when this occurs, the following rules will determine the order of benefit payment as follows:

- NetCare is primary or first payer when the member is:

  -An employee or subscriber
  -Child of a male employee
  -Stepchild (who is a dependent) of a male dependent

- NetCare is secondary (2nd) payer when the member is:

  -Spouse of employee or subscriber
  -Child of female employee
  -Employed child of employee or subscriber
  -Stepchild of employee
  -Child of divorced employee

The "birthday rule" is usually used to determine who is the primary payer for dependent children. This is done by determining which parent's birthday occurs first or earlier in the year by the month and day.

Section 4.6 Secondary Payer and Benefits Payable:

When NetCare is the secondary payer, the member's charges should be sent first to the primary insurance carrier (primary payer). After the other payer's payment information is received, you will need to subtract the payment amount made from the patient account, then send a copy of the payer's payment statement or explanation of benefits form to NetCare. Our claims management department will then process the submitted expense for normal plan benefits available and when appropriate, issue payment for any remaining covered expenses.

Secondary payable benefits are determined in the following manner:

- The other payer's payment will be subtracted from the usual and reasonable charges as determined by comparing for similar care and treatment in the provider's geographic area.

- The balance will be paid up to 100% of the usual, reasonable and customary charges, but not more than the normal plan benefits available.

- If the primary payer has a preferred provider reimbursement agreement, the secondary payment will be limited to the agreed upon amount with the primary payer (unless NetCare's contracted rate with the provider is at a lower cost).

Section 4.7 Balance Billing

The member ***may not*** be billed for the difference between the provider's charged amounts and the NetCare contracted reimbursement amount.

Section 5: Explanation of Provider Payment

Section 5.1 Provider Payment

Each time medical expenses are submitted and plan benefits are assigned and approved for payment to the provider of services, NetCare will issue and transmit an Explanation of Payment or Provider Payment Transmittal Report along with the check payment that explains how the claim was processed and how to compute the amount owed and billable to the member, should there be any outstanding balance due to the provider after NetCare's payment.

NetCare is obligated contractually and by Guam law to reimburse providers within forty five (45) days from the date of receipt of a clean claim.

Section 5.2 Explanation of Payment Statement Content

The Explanation of Payment or Provider Payment Transmittal Report will explain the group coverage for the submitted expenses. Attached is a sample copy of the Provider Payment Transmittal Report.

Following is a detailed description of the Provider Payment Transmittal Report:

- The top portion of the report will list the name of the **provider and address**
- ***Claim Number***: This column list the claim number of the claim submitted and is automatically assigned by the claims system.
- ***Check Date:*** This is the date that the check was printed
- ***Check* Number**: This is the check number automatically assigned by the claims system.
- ***Check Amount***: This is the total amount of the check payment.
- ***Employee/Subscriber Name***: This column list the name of the subscriber.
- ***Dependent Name***: This list the name of the dependent incurring the service.
- ***Social Security Number***: This list the Social Security Number of the member incurring the service.
- ***Patient Account Number***: This column list the patient account number which will be the number provided by the provider on the claim.
- ***Received Date***: This list the date that the claim was received by NetCare.
- ***Incurred Date*:** This list the date that the service was incurred.
- ***Coverage Code***: This list the coverage code provided on the claim form.
- ***Procedure Code***: This list the procedure code that was performed by the provider.

- ***Charge Amount***: This column list the total amount charged by the provider as listed in the claim form.
- **Deductible Amount**: This list the applicable deductible amount applied to the claim payment.
- ***Not Covered Amount*:** This list the amount not covered under the benefit policy.
- ***Employee Amount:*** This column list the amount that the member is financially responsible for paying to the provider.
- ***Paid Amount:*** This list the total amount NetCare has paid based on the claim form submitted.

Section 6: Pre-Certification Policy & Procedures

Section 6.1 Pre-certification Policy

This section explains the process and requirements for pre-certifications pertaining to outpatient services, procedures and hospitalization. Pre-certification is the process in which NetCare's medical management department compares a member's need for a non-emergency service to established criteria.

The purpose of this review are two-fold:

1. To determine the medical necessity of the service
2. To determine the appropriate setting for the service

Section 6.2 Services Requiring Pre-certification Approval

Pre-certification is required whenever a member is scheduled for any of the following common procedures:

- Outpatient elective surgery or procedures (excludes Bilateral Tubal Ligation, Caesarian Section for a Previous CS delivery, Herniorrhaphy, Cataract Extraction)
- Skilled Nursing Facility Admission
- Rehabilitation Facility Admission
- Hospice Care
- Home Health Care
- Major Diagnostic Procedures (MRI, CT-Scan, PET Scan, Ultrasounds)
- Endoscopic Procedures
- Gamma Knife Procedures

NOTE: Off-island pre-certification includes services and procedures mentioned above in addition to inpatient hospitalization.

The above listing of procedures provides only examples. Please be sure to contact NetCare's Medical Management Department for information and clarification on other procedures requiring pre- authorization approval.

Section 6.3 Required Documentation for Pre-certification

When submitting a pre-certification authorization request, please include the following:

- Member or Patient Name (include Member I.D. Number)
- Date of Birth
- A completed and legible pre-certification form provided by NetCare
- Name of referring physician
- Name of physician performing the requested service
- ICD-9/CPT codes pertinent to the requested service
- Clinical Documentation to support the requested service
- Contact name, phone number, fax number and location if provider has more than one location.

Section 6.4 Procedures for submitting a Pre-certification Request

1. Patient and Physician determine the need for a procedure, test or service and submit a pre-certification encounter approval to NetCare.

2. Physician notifies its nurse coordinator to obtain a pre-certification authorization for the procedure or test with NetCare.

3. Nurse Coordinator pulls a member's medical record or chart and copy of insurance card.

4. Nurse Coordinator determines if member has another third party insurance coverage.

5. Nurse Coordinator completes the NetCare Pre-certification Form and attaches any required documentations and submits the Pre-certification request to NetCare via Facsimile at (671) 472-3615 or (671) 472-6375.

6. NetCare's Medical Management Department receives the pre-certification request and verifies benefits and eligibility as well as review the procedures or testing requested from the physician for medical necessity and established criteria.

7. NetCare's Medical Management Department will respond within twenty four (24) hours from receipt indicating an approval with an authorization number, a denial of the request stating the reason for the denial or a modification stating NetCare's recommendation and comments or a denial of the request.

8. If pre-certification request is approved by NetCare, then the physician's nurse coordinator is responsible for sending the approved

pre-certification form with the insurance coverage information to the respective billing department or business manager.

9. The physician's nurse coordinator is also responsible for ensuring a scheduled appointment for the member using the authorization number provided by NetCare.

Section 6.5 Appeal Process for Pre-Certification Denials

The following process or procedures are established for an appeal of any denial decisions:

1. The member or physician has the right to appeal a negative decision or denial or limited payment of benefits.

2. The appeal must be made in writing, giving all pertinent information and reasons for the reversal of decision.

3. The written appeal can be mailed to NetCare's administrative offices at 424 West O'Brien Drive, Julale Center, Hagatna, Guam 96910 or by facsimile at (671) 472-3615 or 472-6375 or via e-mail at bgonzalvo@netcarelifeandhealth.com.

4. A physician reviewer will review the appeal and recommend a written course of action or opinion to NetCare's Medical Management Department and Plan Medical Director.

5. The decision of the Plan's Medical Director will be made in writing to the member and physician and will be **FINAL**.

6. The written decision by the Plan's Medical Director will state the affirmation, modification or reversal of the decision made.

Section 6.6 Time-frame for making an appeal

1. Members and physicians intending or wishing to appeal a negative decision must do so within thirty (30) days of learning of the decision.

2. NetCare will review the case and appeal request within ten (10) working days following receipt for appeal and provide a written decision.

Section 7: Prescription Drug Policy

Section 7.1 Drug Formulary and Prescription Guidelines

NetCare's Drug Formulary and Prescription Guidelines (with flexibility based on medical necessity) is the cornerstone of the drug therapy, quality assurance and cost containment efforts. The Drug Formulary process has been successfully used by hospitals and providers to provide comprehensive, cost-effective pharmacy services to members. NetCare has adopted a *Mandatory Generic Incentive Program* which essentially means that only generic brand medications are covered, unless there is no generic substitute or equivalent available. NetCare's Prescription Formulary is based on a three (3) tier co-payment policy based on generic drugs; brand drugs; and non-formulary drugs.

The Drug Formulary and Prescription Guidelines was developed by NetCare's Pharmacy and Therapeutic Committee with the assistance and guidance of our Pharmacy Benefit Management (PBM) partner, ***NMHC Rx***. This committee, composed of physicians from various medical specialties, and pharmacists reviewed the medications in all therapeutic categories based on safety, effectiveness, and cost and selected the most effective agent(s) in each class.

NetCare's Pharmacy and Therapeutic Committee will regularly review new and existing medications to ensure the formulary remains responsive to the needs of our members and providers.

Section 7.2 Requesting for Change in Drug Formulary

If a provider requests that a new or existing medication be added to the Drug Formulary, a written letter indicating the significant advantages of the drug product over current drug formulary should be mailed to NetCare's Pharmacy and Therapeutic Committee.

A provider's request for formulary additions or deletions will be reviewed based on the following criteria:

- The drug meets a justifiable need not already met by a drug in the formulary or recommended to replace a formulary drug.
- If the drug is to replace another formulary agent, it is of superior or equal therapeutic value or it displays fewer or less severe adverse effects.
- Indications for use, pharmacology and biopharmaceuticals, efficacy as documented by clinical study and side effects or toxicity.

- FDA Approval Rating
- Cost of the drug therapy

Section 7.3 Prescribing Policies for Outpatient Pharmacy Programs

In order to maintain standardization throughout the program, the following prescribing guidelines should be followed:

1. Each prescription should be for one (1) patient only or if for more than one patient, each family member's name should be on the prescription. This will allow for the proper assessment of co-payments by the pharmacy.

2. There should be no more than two drug orders per prescription blank, to ensure the clarity of each prescription.

3. The formulary should be used as a guide to selecting cost effective medications when prescribing.

4. Providers should allow generic substitution whenever possible.

5. In order to reduce the risk of adverse effects to members, NetCare will not cover or authorize prescription drugs when prescribed for experimental, investigational or non-FDA approval purposes.

Section 7.4 Non-Formulary Requests

When a prescription drug is indicated for the member's treatment, physicians are encouraged to prescribe from the drug listing contained in the formulary. Should a non-formulary drug be necessary for the optimal treatment of the member, physicians may prescribe the non-formulary drug based on medical need and effectiveness. Prescriptions for non-formulary drugs **are not** required to be pre-certified and approved by NetCare. However, The member will be required to pay for the non-formulary co-payment plus the difference between the generic brand and the non-formulary brand cost.

Section 7.5 Over-The-Counter (OTC) Medications

While not covered, OTC medications are promoted within the formulary prescribing guidelines. OTC medications when utilized appropriately can reduce prescription utilization and drug costs. Physicians and pharmacies should refer patients to OTC medications when appropriate.

Section 7.6 Outpatient Prescription Formulary List

Attached is a copy of NetCare's Prescription Drug Formulary and Prescription Guidelines for your resource and information.

Section 8: Referral Policy and Procedures

Section 8.1 Referral System

Although, NetCare does not require referrals to participating providers under the Guam Benefit Plans, we do require referrals for members enrolled under the CNMI and Palau Benefit Plans when a referral is outside of the CNMI or Palau.

Referrals can be made for three purposes:

1. To obtain a consultation from another physician

2. To transfer a patient to another physician for treatment or care

3. To treat a condition due to a physician's limitations

Section 8.2 Referral Procedures off-island

From time to time, an off-island referral will be necessary for members requiring catastrophic care, tertiary care, consultations or second surgical opinions. NetCare's off-island network of participating providers is available for you to refer members to.

To refer a member to one of NetCare's participating providers off-island, please contact our customer service department at (671) 472-3610 for more information and referral requirements.

The following is a listing of off-island participating providers:

United States Mainland:

First Health Network
10260 Meanley Drive
San Diego, California 92131
Phone: (858) 547-2500
E-Mail: www.firsthealth.com
(350,000 Participating Providers nationwide)

California:

Anaheim Memorial Medical Center
White Memorial Medical Center
Good Samaritan Hospital

Hawaii:

Straub Clinic & Hospital
Kapiolani Medical Center
Diagnostic Laboratory Services (DLS)
Honolulu Medical Group

Philippines:

Makati Medical Center
St. Luke's Medical Center
The Medical City Medical Center
Cardinal Santos Medical Center
Philippine Heart Center
Asia Hospital & Medical Center

NetCare also maintains a full service medical liaison office in Manila, Philippines staffed by two medical assistants. The office is located in the St. Luke's Medical Center Medical Arts Building. The phone number is (632) 725-2150 or via fax at (632) 727-2232.

Section 8.3 Centers of Care (COC) Facilities

NetCare has contracted with a select number of medical facilities to perform high-cost, chronic and catastrophic procedures such as coronary by-pass surgery, cancer treatment, liver, kidney or bone marrow transplants, neurosurgery and gamma knife.

As a participating provider, you may contact NetCare's customer service or provider relations department if you wish to refer a patient to one of these Centers of Care facilities.

To qualify for 100% coverage of covered services at any of the designated Centers of Care facilities, a member must meet the established criteria before prior authorization is approved by NetCare's medical management department. You may contact NetCare's medical management department for further information

NetCare's Centers of Care Facilities include:

- Anaheim Memorial Medical Center (Los Angeles, California)
- Good Samaritan Hospital (Los Angeles, California)
- White Memorial Medical Center (Los Angeles, California)
- Makati Medical Center (Philippines)
- St.Luke's Medical Center (Philippines)
- Philippine Heart Center

Section 9: Provider Grievance Policy

Section 9.1 Provider Complaints & Grievances

NetCare has established a mechanism for participating providers to communicate problems, concerns, questions and issues regarding billing disputes to our Provider Relations Department by telephone, in writing or in person. Many of these issues can be addressed very quickly following a brief investigation.

Provider complaints or disputes fall into three categories. They are:

1. Reimbursement Decisions - When a provider disputes a specific claim adjudication outcome including, but not limited to, bundling, reimbursement and provider responsibility.

2. Authorization or denial of services - When a provider disputes a prior authorization or pre-certification request

3. Agreement/Contract – When a provider disputes administration of a provider agreement.

Section 9.2 Grievance Procedures

Providers may submit a written grievance to NetCare. Grievances may pertain to such issues as the authorization or denial of a service or the processing, payment or non-payment of a claim or other issues. All written formal grievances will be responded in writing with a closure letter by NetCare within 30 calendar days of receipt of a written grievance notice from provider.

1. You must submit a written, detailed "Request for Reassessment" within 30 days of the action or decision you want to dispute or file grievance with. This letter must be submitted to the following address:

   NetCare Life & Health Insurance Company
   Attn: Provider Dispute Resolution
   424 West O'Brien Drive, Suite 200, Julale Center
   Hagatna, Guam 96910

The Request for Reassessment must include a detailed discussion of the disputed issues, the basis for your disagreement, all evidence and documentation supporting your position and the action you desire from NetCare.

Please be advised that if you do not submit a complete and timely Request for Reassessment," you will be deemed to have accepted our determination and to have waived all further internal, external, judicial or arbitral processes.

2. The NetCare staff member receiving the initial call or Request for Reassessment shall make every effort to personally resolve the complaint to the satisfaction of the Provider during the initial contact.

3. If additional information from an outside source is needed in order to resolve the complaint, the NetCare Plan Administrator shall investigate the complaint and gather the necessary information from outside sources or references.

Section 10: Utilization Review and Quality Assurance

Section 10.1 Purpose of Utilization Review

NetCare's Utilization Review Program is committed to providing health care services to our members that is medically excellent, ethically driven and delivered in a patient-centered environment that recognizes the positive relationship between the health education, a culture of wellness, and emphasis on prevention and the cost effective delivery of care.

The purpose is to ensure consistent delivery of the highest quality health care and to optimize positive member outcomes. This is accomplished through the establishment of a fully integrated provide network and the coordination of all clinical and administrative services.

Section 10.2 Goals

- Consistently apply Utilization Review standards, guidelines, policy and procedure in the evaluation of medical care and services on a concurrent, retrospective and prospective basis.

- Provide access to quality healthcare services delivered in the most appropriate and cost effective setting.

- Facilitate and ensure continuity of care for members within and outside the service area.

Section 10.3 Provider Responsibilities

Although, members are not required to select a primary care physician, they may choose any of NetCare's participating providers as their primary care provider whether you are a primary care physician or a specialist care physician.

As a participating provider, you are responsible for the following activities:

- Provide appropriate and cost-effective care consistent with NetCare's Utilization Review plan, its protocols, standards and guidelines.

- Submit complete and timely claims to NetCare for processing. NetCare shall have access at reasonable times and upon reasonable demand to a

participating provider's books, records and consultation information pertaining to a NetCare member for the purpose of processing and auditing claims.

- Providers will refer patients within NetCare's contracted provider network to the fullest extent and most reasonable extent possible within and outside the service area.

- NetCare providers may also be requested to assist in the evaluation of medical appropriateness of care provided to their patients or of care provided by other participating providers, either on an individual basis or as part of the Utilization Review Committee.

Section 10.4 Utilization Review Committee Structure

The Utilization Review Committee is composed of NetCare's Director of Medical Management Services who chairs the committee. Membership is assigned and will include participating providers representing two (2) primary care physicians and two (2) specialty care physicians. The physician members of the Utilization Review Committee are chosen based on the significance of their NetCare membership and knowledge and understanding of the utilization review process.

The Utilization Review Committee meets on a quarterly basis and is responsible for the following:

- Reviewing and discussing administrative information presented to the members
- Reviewing utilization management statistics and data
- Receiving, reviewing, evaluating and making recommendations regarding utilization review and quality improvement activities.
- Reviewing proposed member treatment plans requiring input beyond the expertise of the Director of Medical Management Services and Medical Management Specialist.
- Coordinating educational opportunities for participating providers and medical management staff regarding utilization review policies and procedure processes.

Section 10.5 Utilization Reports

The following reports are reviewed in the Utilization Review Committee meetings:

- Total Hospital bed days per 1000
- Average length of stay (LOS) per patient
- Average number of patients per day
- Total number if hospital admissions per month (by specialty)
- Total number of referrals off-island by specialty
- Total number of pre-certification approved, deferred, denied and modified as well as pre-certification type (e.g. Home Health care, Diagnostic Procedure, Surgical Procedures)
- Pre-certification and claims appeals
- Emergency Room Utilization
- Pharmacy Utilization
- Number of Approved and Authorized Airfare Benefit
- Review if cases for Disease Management and Case Management

Section 10.6 Utilization Review Activities

NetCare's Utilization Review Activities consist of pre-certification review (which is discussed under Section 6 of this Manual); concurrent review, continued-stay review, discharge planning, retrospective review, prospective review, and case management.

- ***Concurrent Review***

  For concurrent review of services, NetCare makes decisions for inpatient services at the time of onsite visit. The concept involves determining whether treatment and continued inpatient care during a patient's hospitalization are necessary and appropriate. Monitoring of daily hospital admissions as well as performing concurrent review is handled by NetCare's Medical Management Specialist who is a Guam licensed Registered Nurse (RN). The medical management specialist reviews a patient's chart immediately following admission and at suitable subsequent intervals for the following:

  - To assign an initial length of stay, if not already done, and assess the medical need for any extensions;
  - To assess the treatment program and efficacy of the care being given;
  - To abstract data for retrospective quality assessment in comparison with medical care criteria.

  The medical management specialist can authorize care that falls within pre-determined, explicit quality and length of stay guidelines. These guidelines are based on common practice and experience. NetCare utilizes and subscribes to the InterQual Utilization Management Guidelines.

Within 24 hours of each admission, the medical management specialist initiates a thorough review for a patient. Using diagnosis-specific criteria or general quality guidelines, the process begins with an initial chart review to determine the need for admission. If the chart does not clearly indicate the needed information, the medical management specialist will request clarification from the attending physician.

Next, the appropriateness of the level of care is determined. Potential levels of care include intensive, acute, extended or rehabilitative, supportive, ambulatory, coordinated home health, and hospice care.

The medical management specialist also assigns a diagnosis-specific length of stay range during the initial review. The length of stay range may be defined within a minimum that represents the median length of stay determined necessary to ensure quality care and a maximum that represents a limit based on the Milliman & Robertson Inpatient Hospitalization Guidelines. NetCare must be advised of the need for an extended hospital stay with justification of the medical necessity (as evidenced by the inpatient medical information and progress report) for the extended hospitalization beyond the approved or allowed maximum.

The date representing the minimum length of stay is noted in the patient's chart. On that date the patient's length of stay is reviewed again, and the medical management specialist, after looking at the patient's chart, may assign a new review date.

- ***Continued-Stay Review***

Continued-stay review is an off-site medical review conducted during the member's hospitalization. It is primarily based on telephone conversations between the medical management specialist and the attending physician, hospital utilization review staff or discharge planning staff. Telephone contacts are made at designated intervals consistent with the patient's conditions until discharge occurs.

Using established medical criteria and length of stay norms, NetCare's medical management specialist determines the medical necessity and appropriateness of both treatment plan and length of inpatient stay. This is conducted in coordination and consultation of the patient's physician.

- ***Discharge Planning***

  NetCare's medical management specialist will work jointly and in coordination with a patient's physician to begin any discharge planning as early as possible.

  For patients who have not fully recovered but who do not require the acute care of a hospital, NetCare can make arrangements for continuing care in a less costly setting, such as skilled nursing facility or to a home health care agency as an alternative to a hospital set-up.

  NetCare is committed to ensuring that our patients receive the proper care in the most appropriate setting after a hospital stay.

- ***Retrospective Review***

  The retrospective review process determines the appropriateness of the care that has been provided and the extent to which health care costs should be reimbursed. This process allows NetCare to establish utilization profiles for use in monitoring trend factors, including diagnoses, the fees charged for medical services, and where they were provided.

  In retrospective review of outpatient utilization, NetCare establishes the appropriate treatments for a given diagnosis in terms of tests required, and office visits permitted. When claims are received, they are reviewed against these treatment guidelines. Any treatment that does not fall within the guidelines must be justified by the provider or it may be denied for payment.

- ***Prospective Review***

  NetCare's medical management department performs prospective review for skilled nursing care, surgery and certain outpatient services. Major emphasis and focus is on managing the use of in -hospital services.

- ***Case Management***

  Case Management is a planned approach to providing services or treatment to a member with a serious medical or chronic problem. It is aimed at effectively managing costs and promoting more effective interventions to meet patient's needs.

NetCare strongly emphasizes and makes benefits available for appropriate and cost-effective health care services including alternatives to hospitalization such as home health care services.

NetCare's case management program is designed to identify catastrophic illness or injury cases as early as possible. NetCare will identify individual claims with amounts of $5,000 or aggregate claims above $10,000 for one covered member. As a participating provider, you can alert our medical management department about a potential case management patient.

Section 11: Anti-Fraud and Abuse Policy

Section 11.1 Anti-Fraud Policy & Program

NetCare has developed an aggressive Compliance and Anti-Fraud Program which includes voluntary disclosure to appropriate agencies of alleged cases of fraud and abuse. Provider cooperation is essential for the success of anti-fraud and abuse efforts and as a participating provider with NetCare, we would like to draw your attention to this program and request your cooperation.

Health care fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, member, employee, supplier or other entity makes knowing that such action could result in an unauthorized payment, benefit, denial, or other illegal action would come under health care fraud.

Section 11.2 Ways to Cooperate with NetCare's Anti-Fraud and Abuse efforts

Review your practices relating to services to NetCare members to ensure that:

- Fee-for-service bills accurately describe the actual services performed and duplicate billing is avoided;
- Members are not billed for covered services except for applicable co-payments, deductible and non-covered services;
- Co-payments are collected at the time of service from the member (or as agreed upon by the Provider and the member);
- You keep NetCare informed about renewals and changes to your licenses and other credentials;
- You accurately state diagnosis and medical necessity, and maintain accurate medical records;
- You maintain confidentiality and privacy of member's medical records.

Section 12: Disease Management & Wellness Program

Section 12.1 Disease Management Policy

The key to success in managing any chronic diseases and wellness issues is ***education*** and ***awareness***. NetCare believes that in order to reduce medical costs, we must first empower those members affected to take proper care and become aware of their progress in order to gain control over their health and quality of life.

The goals of NetCare's Disease Management & Wellness Program is to:

- To help a member manage their disease, reduce disease-related health problems and improve their quality of life.
- To achieve consistent, quality of care and improved disease outcomes by using clinical guidelines and best practices.
- To work with a member's physician by providing them with confidential reports and opportunities to improve disease management and treatment plans.

Section 12.2 Listed Diseases

The following listed diseases or conditions are recognized by NetCare as qualifying for disease management & wellness program:

- Asthma
- Cancer
- Diabetes
- Heart Disease
- Hypertension
- Hyperlipidemia
- Hyperchoelsterolemia
- Complicated Pregnancy

Section 12.3 Disease Management & Wellness Programs

NetCare's Disease Management & Wellness Program consists of three separate programs. You can contact NetCare's Medical Management department for more detail information on the following programs and activities:

A. ***Special Direct Access Program***

NetCare has developed several benefit programs that allow NetCare members to receive care directly without ever needing a referral or pre-certification for treatment. These include:

- ***Well Woman Advantage***
- ***Vision Direct***
- ***Chiropractic Direct***
- ***Podiatry Direct***

B. ***Passport to Wellness***

NetCare's Passport to Wellness is a collection of wellness programs and activities designed specifically for NetCare members to encourage and support a healthy lifestyle. These programs include:

- ***Great Expectations Pregnancy Program***
- ***Smoking Cessation***
- ***Jenny Craig Weight Loss Program***
- ***Fitness Club Membership***
- ***Discount Programs***
- ***Work Site Health Fairs***

C. ***Disease Management Program***

- ***In Control Diabetes Program (Roche Diagnostics)***
- ***Great Inspirations/NewStart Program (SDA Wellness Center)***
- ***Self-Care Health Resources(MediLine)***
- ***Health Education Classes***

NetCare's medical management department can assist you and coordinate all necessary referrals to participating providers or partners for disease management and wellness programs.

Section 13: HIPAA Privacy Practices

Section 13.1 Privacy Policy

The protection of our members' health information is important to us at NetCare. Attached is NetCare's Notice of Privacy Practices which describes a member's health information privacy rights pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NetCare has provided a copy of this Privacy Practices to all enrolled subscribers in order for them to become familiar with how personal health information will be used and safeguarded, as well as rights regarding the protection of a member's personal data.

NetCare is committed to the responsible management, use, and protection of non-public personal information. Personal information in this notice means information that identifies an individual personally and is not otherwise available to the public. This may include financial information such as credit and income history, policy benefits, social security numbers, and billing and claims information. It may also include personal health information such as medical records and claims activity.

As a NetCare participating provider, you are required by federal law to protect a member's non-public personal or protected health information.

Section 13.2 Privacy Officer

For questions or issues on the HIPAA Privacy Practices, please contact NetCare's Privacy Officer at the following:

Venida Farnum
HIPAA Privacy Officer
NetCare Life & Health Insurance Company
424 West O'Brien Drive
Julale Center
Hagatna, Guam 96910

Section 13.3 Security Officer

For questions and issues pertaining to the security of electronic submission or if you are interested in submitting claims electronically, please contact NetCare's Security Officer at the following:

Ed Gozalo
HIPAA Security Officer
NetCare Life & Health Insurance Company
424 West O'Brien Drive, Julale Center
Hagatna, Guam 96910

Section 14: Facility On-Site Evaluation

Section 14.1 Pre-contractual On-Site Review

As a pre-requisite to Provider contracting, NetCare requires an on-site review of your medical facility. This involves the following review criteria:

- Accessibility and Availability
- Ancillary Services
- Emergency Services
- Compliance and Credentials
- Medical Records
- Safety
- Patient Education Materials
- Appointment System

Attached is a copy of NetCare's Pre-contractual On-site Review Application. NetCare also reserves the right to audit and conduct an on-site review of your facility after your one or more years of being a NetCare participating provider. NetCare will provide at least a thirty (30) day notice of any such on-site visit.

Section 15: Medical Plan Benefits

Section 15.1 Plan Benefits

NetCare has the following benefit plans in the Guam market:

- **Standard Plan**

  Description: $10.00/$25.00 Co-payment for outpatient services
  80% Inpatient Hospitalization
  100% Inpatient Hospitalization at Centers of Care
  $5.00 Co-payment for generic prescription
  $10.00 Co-payment for brand prescription
  $25.00 Co-payment for non-formulary prescription
  10% Co-insurance for injectible drugs

- **Prime Plan**

  Description: 20% Co-payment for outpatient services
  80% Inpatient Hospitalization
  100% Inpatient Hospitalization at Centers of Care
  $5.00 Co-payment for generic prescription
  $10.00 Co-payment for brand prescription
  $25.00 Co-payment for non-formulary prescription
  10% Co-insurance for injectible drugs

- **Access Plan**

  Description: $500 Deductible
  20% for Outpatient Services after Deductible
  80% for Inpatient Hospitalization after Deductible
  $5.00 Co-payment for generic prescription
  $10.00 Co-payment for brand prescription
  $25.00 Co-payment for non-formulary prescription
  10% Co-insurance for injectibles drugs

- **Advantage Plan**

  Description: $10.00/$25.00 Copayment for outpatient Services
  Must Select a Primary Care Physician
  $100 co-payment each day for inpatient hospitalization up to five (5) days.
  $5.00 Co-payment for generic drugs
  $10.00 Co-payment for brand drugs
  $25.00 Co-payment for non-formulary drugs

10% Co-insurance for injectible drugs

NetCare also has several benefit plans called "Standard Modified" with varying co-payments for both outpatient and inpatient services. These are customize benefits for specific group accounts. You may contact NetCare's customer service department for more information on these group accounts.

Pleased refer to the attached Medical Benefit Plans for detailed information and description of specific benefit coverage for CNMI and Palau markets.

Section 16: Provider Application & Credentialing

Section 16.1 Provider Application

As a pre-requisite to contract, NetCare requires the completion of a Participating Provider Application for every physician wishing to become a NetCare Participating Provider.

Each time you add a new physician to your practice, you are required to have that physician complete a Participating Provider Application for our review, credentialing and record. This is especially important if that physician will be providing service and treating NetCare members.

The Participating Provider Application requires you to provide the following information and documentation:

- Board Certifications or eligibility
- Professional liability Insurance information
- Medicare Assignment
- Billing and Primary Address
- Hospital Affiliations
- Office or clinical hours
- Educational Background & Residency Information
- Malpractice Information
- Copy of Fee Schedule
- Copy of Professional Liability Insurance Policy
- Copy of Guam License Registration Certificate
- Complete Confidential Questionnaire

Section 16.2 Credentialing

NetCare performs credentialing as a pre-requisite to contracting. This process involves verifying all physician credentials including educational background, residencies, hospital affiliations and malpractice information.

NetCare also re-credentials all providers under contract with NetCare at least every two years. The re-credentialing process includes verification of:

- Drug Enforcement Administration (DEA) registration number if the scope of practice would warrant the physician to have a DEA.

- Professional Liability – minimum amount required per occurrence and per aggregate
- Admitting privileges at Guam Memorial Hospital
- Clear report from the National Data Bank
- Board Certification or Board Eligible, if not Board Certified or Board Eligible, the physician must demonstrate appropriate training for specialty listed.
- Proof of medical license
- Sufficient information concerning any malpractice actions pending or resolved in the last five years.
- Completed confidential questionnaire

Section 17: NetCare's Contact Directory

Section 17.1 How to Contact NetCare

NetCare's Customer Service and/or Provider Relations Department are able to assist you and your staff regarding any problems, issues and questions you may have.

You may contact our administrative offices during the weekdays, Monday thru Friday, between the hours of 8:00 am and 5:00pm.

NetCare's Contact Numbers are:

424 West O'Brien Drive
Julale Center, Suite 200
Hagatna, Guam 96910

Phone: (671) 472-3610/14
Facsimile: (671) 472-3615 or (671) 472-6375
E-Mail: mpoblete@netcarelifeandhealth.com

Section 17.2 Whom To Call

- For eligibility questions or verification, call customer service at 472-3610/14
- For questions pertaining to your claims payment, call provider relations at 472-3610
- For questions pertaining to pre-certification or prior authorization, please call medical management at 472-3612
- For questions pertaining to benefit plans and coverage, call customer service at 472-3610/14

Section 18. Web Site Procedures

Section 18.1 Benefit and Claims Information On-Line

NetCare remains committed to utilizing a variety of technologies in order to streamline and improve communications and business processes. Therefore, from your office computer, you can log into NetCare's secure and HIPAA compliant website at www.netcarelifeandhealth.com and access and view information about claims status, benefit plan information and coverage, verification of eligibility, provider services and medical resources.

By utilizing NetCare's website, you will improve your office functionality and increase efficiency.

Section 18.2 Accessing the Information

There are three (3) important but simple steps involved in accessing information from the website:

1. **Sign-Up**. From the Internet, go to www.netcarelifeandhealth.com. Then click on "**I AM A PROVIDER**" link. Once there click on **PROVIDER SIGN UP** and follow the simple instructions to complete the form, as it relates to yourself and your practice. This link will take you to the MediWeb Provider Services Portal. Please be sure to include your e-mail address. This is the address that we will use to contact you and communicate provider service and other information to you, including system changes and approval.

2. **User Name and Password**. Use a name and password that only you will know, we offer you a chance to ask your own hint question, in case you forget your password.

3. **Sign In and Use**. Once we have received your sign-up, we will review and approve your request to view claims and verify patient eligibility. You will be notified of the approval via the e-mail address you provided at the time of sign-up.

Section 18.3 Provider On-Line Services

NetCare offers the following on-line services for providers:

- Provider Information including applicable forms such as Pre-certification Authorization Form
- Provider Inquiries on claims, benefit coverage and eligibility
- Website Resources on medical information and frequently asked questions and answers
- Systems Services listing announcements and provider updates

Please see the following pages for a more detailed description of each on-line service.