Provider Manual

Medical Services

Introduction and Commitment to Providers

Introduction to the Provider Manual

Welcome to Quad City Community Healthcare. We are pleased you have elected to become a participating physician or provider in an effort to provide our Members with high quality, cost-effective medical care.

This Provider Manual introduces you to Quad City Community Healthcare. We are confident you will find this information useful and hope that you and your office staff will read it carefully. From time to time, there may be changes in established policies and procedures. We will let you know about these changes as quickly as possible to ensure proper administration. When such changes occur, the updates will be available via the Provider Page on the Quad City Community Healthcare website (*https://www.QCCHhealth.com/*). Please note, provisions in your contract will supersede the information in this manual if there are items that conflict.

We are your LOCAL health plan and we understand that your support and involvement are critical to our success. Therefore, we encourage you to share with us your thoughts on how we can improve our products or services. Please feel free to call our Provider Services Department anytime should you have questions or concerns, or wish to discuss your participation in our network.

The Provider Services Department can be reached at the following:

Quad City Community Healthcare
PO Box 389
Dubuque IA 52004-0389
Phone: (800) 457-4726
Fax: (563) 587-6556

Normal Business days, Monday - Friday 8:00 am to 5:00 pm

Again, we appreciate your participation in the Quad City Community Healthcare Provider Network. We look forward to working with you to manage our health care programs and serve the needs of our Members.

Our Provider Service Commitment

Provider Service Representatives have the responsibility for ensuring that all of our providers have a positive experience with our Plan when they call or visit our office. They are experienced and friendly, and strive for prompt issue resolution. Our Provider Service Representatives are the liaison between Quad City Community Healthcare and our providers and have the unique opportunity to help our members by communicating in a knowledgeable and pleasant manner, while respecting the needs of our providers. It is with this type of local quality service and prompt issue resolution that sets Quad City Community Healthcare above other, larger national competitors.

Quad City Community Healthcare's Provider Service Representatives are dedicated to:

- Answering the phones pleasantly and promptly.
- Treating the provider and office staff with respect, understanding and compassion.
- Listening attentively and asking appropriate questions to accurately interpret the needs of our providers and office staff.
- Striving for prompt issue resolution with consistent and accurate responses to demonstrate superior quality service.
- Reviewing customer satisfaction statistics to enable them to perform their job duties in an informed and efficient manner.
- Documenting their actions to provide verification and consistency of responses.
- Educating our providers and their staff on Quad City Community Healthcare benefits and procedures.

As part of our effort to continuously improve, Quad City Community Healthcare monitors our Provider Service statistics with the goal of exceeding the service expectations of our providers and their office staff.

Quad City Community Healthcare

For local customer and provider service and quick issue resolution

Dial
800-457-4726
Fax
563-587-6556
Email
CBHP@siscobenefits.com

Speak directly to a friendly and experienced Service Representative

Our normal business hours are Monday thru Friday from 7:00 am to 5:00 pm central standard time.

If there is a medical emergency, call 911 or go to the nearest Emergency Facility.

Participating Provider Commitments

24 hour Access to Medical Care

Provisions for 24 hour access to medical care

Providers shall have the appropriate methods for directing patients to seek medical care when they themselves are not available. The provider shall arrange for the provision of emergency situations 24 hours a day, 7 days a week.

Providers shall provide information to the patients on how they may seek medical care when the provider is not available for times such as normal business hours, lunch, vacation, or after hours.

Providers shall arrange for coverage with another in plan provider during times when unavailable. After hour answering services and or systems must be in place for patients to be directed on how to reach the provider or another provider designated to treat the patient.

After hour telephone access to providers

Providers or designated provider providing coverage, shall return a patient's telephone call within one hour of receiving the call after regular office hours.

Appointment Standards to Access Providers of Care

Emergent Crisis Care is defined as the evaluation and management of a condition, injury or illness with symptoms that require immediate attention or care when the patient is in jeopardy of a life threatening or permanent injury/disability if appropriate medical care is not immediately provided.

Emergent Crisis Care patients should be seen immediately or referred to an emergency care facility as appropriate.

Urgent Care is defined as the evaluation and management of an unexpected condition, injury or illness that is not life threatening or could cause permanent injury/disability that cannot be reasonably postponed but is not considered emergent.

Urgent Care patients should be seen within a 24 hour period as appropriate.

Routine Care is defined as a) care for a non-symptomatic patient involves evaluation and management of an established patient including patient history, physical examination, preventative screening, immunizations and medical decision making b) care for a symptomatic patient involves evaluation and management of a symptomatic new or established patient for chronic disease management, problem focused history, physical examination and medical decision making.

Routine Care patient non-symptomatic should be seen within 4 weeks as appropriate.

Routine Care patient that is symptomatic should be seen within 5 days as appropriate.

Initial Appointment is defined as a new patient not seen by the provider within the last 36 months as care for a new non-symptomatic patient involving the evaluation and management of patient including patient history, physical examination, preventative screening, immunizations and medical decision making.

Initial Appointment patients should be seen within 8 weeks as appropriate.

Providers participating with Quad City Community Healthcare agree to accept patients if their practice is accepting patients that are participating with other health insurance payors/carriers and hold the same office hours and policies without discrimination with other payors/carriers.

In Office Wait Time

If a patient is scheduled for an appointment and arrives on time, the wait time should be less than 30 minutes.

Wait time should be measure from the scheduled appointment time until the provider sees the patient.

If an unforeseen circumstance should arise that would make it impossible to see the patient within the 30 minute wait time period, the office/clinic staff should offer the following options:

- Explain an unforeseen circumstance has arisen
- Offer the patient to continue to wait
- Reschedule the appointment

Member Eligibility and Benefits Information

Verification of Eligibility and Benefits

Providers of service to QCCH members should review member ID cards for verification and identification of the member. A member ID card does not guarantee eligibility or participation in the QCCH health plans. Members may change plans, benefits may change, member may term with the plan or there may be fraudulent use of the ID card.

For eligibility and benefit information please contact Customer Service. Verification of eligibility and benefit information is not a guarantee for payment of a claim. Any claim submitted to QCCH will be subject to eligibility and the terms, conditions, limitations and exclusions of the policy at the time of service.

Sample of Fully Insured Group ID Card

Guide to the QCCH ID Card

FRONT CARD ELEMENT	EXPLANATION
Quad City Community Healthcare Logo	The member's health plan. The top of the card also provides the address and telephone number for you to contact Quad City Community Healthcare
MEMBER	
Group Name	Enrolled group's name
Group #	Enrolled group's identification number
Member	Enrolled member's name
Member ID	Enrolled member's identification number
DEPENDENTS	
Dependents	Not listed on the card
MEDICAL PPO PLAN	
In-Network Co pays	Lists the co pays associated with the member's medical plan for covered services when received from a Participating Provider. See your medical plan for more details.
PHARMACY PLAN	
NPS Logo	Quad City Community Healthcare's Pharmacy Benefit Manager (PBM) for pharmacy services
RxBin, Rx PCN, Rx Group	NPS and Pharmacy purposes only
Retail Co pays	Lists the co pays associated with the member's pharmacy plan for covered services. See your pharmacy plan for more details.

BACK CARD ELEMENT	EXPLANATION
MEDICAL CLAIMS SUBMISSION	Address for claims submission. Also includes telephone numbers for members to use in contacting Quad City Community Healthcare.
PREAUTHORIZATION	Reminder to members to show their ID card to their provider. Also includes the telephone number when preauthorization is required in advance of certain services.

Claim Guidelines

The following guidelines are in response to most frequently asked questions. Not all guidelines are listed in this provider manual. If you have questions regarding claims issues or additional claim guidelines please call customer service at 1-800-457-4726.

Providers, practitioners, facilities and ancillary providers must bill on the appropriate CMS approved forms or formats. All providers must bill for services rendered under their unique NPI number and Taxonomy Code. A provider in attendance of the care of a member must bill for the services for that member. Incident to another provider billing is not accepted by the health plan. For billing of Locum Tenens, please contact provider service.

Advanced Beneficiary Notification

Services and Supplies that are not covered by a benefit under a member's health plan require Advanced Beneficiary Notification. Providers of Services and Supplies must provide a member in advance of receiving the service or supplies with a clear and concise written form or document that outlines the member's financial responsibility of services and or supplies that are not covered.

Included in the Advanced Beneficiary Notification of the non-covered service or supply there must be a clear explanation as to why the service or supply is not covered. Reason(s) may be as follows but not limited to the following: no benefit for a service or supply, benefit for a service or supply has been exhausted within the limitations of the health plan, service or supply is cosmetic or for convenience and are not a covered benefit under the health plan.

Both the member and provider must sign the form or document prior to the initiation of any service or supply that is not covered under the beneficiary's health plan in order for the beneficiary to clearly be informed of their financial responsibility prior to the service or supply. Failure to give Advanced Beneficiary Notification may forfeit a provider's right to seek reimbursement for charges not covered under the member's health plan.

Anesthesia Reimbursement Guidelines

Quad City Community Healthcare reimburses for ASA Relative Values. Codes 00100-01999 are reimbursed at ASA base units plus time units when applicable as published in the current years Relative Value Guide by The American Society of Anesthesiologists.

ASA base units plus time units should be billed on the appropriate CMS approved form. Time units should be billed as a unit and not in minutes. A time unit equals 15 minutes. For example 90 minutes equals 6 time units. You would bill the total of adding your ASA base units and the time units together as the "total units". Reimbursement will be made based on the contractual rate multiplied by the total units.

Time is defined in the Relative Value Guide as follows:

"Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient is safely placed under post-anesthesia supervision."

No additional reimbursement is considered for physical status modifiers that indicate complexity.

Add on codes for qualifying Circumstances would not be reported alone but may be reported as additional procedure when such extraordinary conditions or circumstances apply. These codes are listed in the current Relative Value Guide.

Split billing is not reimbursable. The provider in attendance for the majority of the care will bill for the services provided regardless if a different provider begins the procedure and another monitors or completes the procedure.

The following CPT's billed by the specialty of anesthesia will reimburse at the ASA unit rate as specified in the table below. Medical records should accompany the claim for reimbursement to be considered.

99100	Anesthesia for patient of extreme age, under 1 year and over 70	1 (value units)
99116	Anesthesia complicated by utilization of total body hypothermia	5 (value units)
99135	Anesthesia complicated by utilization of hypotension	5 (value units)
99140	Anesthesia complicated by emergency condition	2 (value units)

Assignment of Benefits

Participating providers of service to Quad City Community Healthcare members and dependents will be billed on the appropriate CMS approved forms or approved electronic formats and will agree to accept assignment of benefits on the form or electronically. In the event the appropriate indication is not made to accept assignment of benefits the provider agrees by participating provider status to automatically accept assignment of benefits. For the purposes of this section, "assignment of benefits", accepting assignment is defined as the provider will accept payment directly from QCCH or its payer partner and as per the explanation of benefits the approved charge, determined by the provider agreement fee schedule or exhibit as the full charge for the services covered under the members or dependents benefit plan. The provider will not collect from the member or dependents or other persons an amount that is not equal to the provider agreement fee schedule or exhibit and will not collect from the member other than the applicable deductible, coinsurance or non-covered services.

Assistant Surgery

Quad City Community Healthcare claims processing of assistant surgery claims will follow the payment policies and indicators as per the current year National Physician Fee Schedule Relative Value File as published by CMS. For example, CPT's with an indicator of 2 indicates payment restrictions for assistant at surgery does not apply to this procedure and may be paid. QCCH or its payer partner will reimburse the participating Physician according to his or her fee schedule at 25% of the rate. QCCH or its payer partner will reimburse the participating Physician Assistant or Nurse Practitioner according to his or her fee schedule at 10% of the rate. QCCH does not reimburse Registered Nurse First Assist. The RVU table to determine CPT's that are eligible for assistant surgery reimbursement can be located at www.cms.gov.

Check Issues Resolution

On occasion, a check that has been issued to a provider for reimbursement is either lost or misdirected. In the event that a check is not received by a provider we must wait 30 days from the date of check issue in order to proceed with a check trace and re-issue.

Coordination of Benefits

Quad City Community Healthcare may, in some cases, be secondary payer to a primary insurance plan or a government health plan such as but not limited to Medicare using benefit less benefit methodology. In the event that QCCH is the secondary payer, QCCH will consider the amount after the primary insurance has processed a claim with submission of the primary insurance or government health plan explanation of benefit or remit accompanying the appropriate CMS approved claim form. When considering allowable rates in coordination with the primary insurance plan, QCCH will adjust allowable rates based on member responsibility after the primary insurance has considered all charges. QCCH will not consider an amount greater than what the contractual amount is would have been under the mutual provider agreement and will not consider allowed amounts that would exceed the primary insurance allowed amount.

If the primary insurance has an allowable that is higher than the allowable rate in which QCCH would have allowed had it been the primary payer, QCCH will only consider the contract allowable rate as if QCCH was the primary payer.

If the primary insurance has an allowable that is less than the allowable rate in which QCCH would have allowed had it been the primary payer, QCCH will only consider the up to the primary payer allowable.

When considering coordination of benefits, at no time will QCCH consider an allowable greater than the patient responsibility after the primary insurance has processed a claim.

Contracted providers are required to submit claims in behalf of the member when QCCH is the secondary payer the same as if QCCH had been the primary payer. In addition, contracted providers are required to accept the additional discounts, if any, when QCCH is the secondary payer and refrain from billing these discounts to the member. When QCCH is secondary, the agreement between the contracted provider and QCCH is still in force.

Laboratory Handling Fees

Laboratory handling fees, shipping fees and non-clinical services are not reimbursed under our provider agreements. These services should not be billed to a member. In certain circumstances, it may be medically necessary for a laboratory to provide a service at a member's home. These services will only be reimbursed when medical necessary. Pre authorization is recommended.

Laboratory Professional Component

Providers contracted with Quad City Community Healthcare will not be reimbursed for a professional component for laboratory codes with the exception of pathology and cytology. Professional component of laboratory services is considered inclusive to the cpt code billed as global. QCCH members are not responsible for the professional component of laboratory services. Explanation of benefits and provider remittance will indicate a claims edit or not covered, member not responsible for these charges.

Lesser Of Policy

Quad City Community Healthcare requires providers to bill their usual and customary fee schedules for their practice or facility. This will assist in effectively pricing our fee schedules. Please do not bill contractual rates.

Lesser of will apply. Reimbursement will be the lesser of the billed charge or the contracted rate listed on the exhibit or fee schedule.

Modifiers

Modifier	Description	Information Required 1-Medical Records 2-Operative Report 3-Both 1 & 2 4-No Records
21	Prolonged Evaluation and Management Services	1-Medical Records
22	Increased Procedural Services	3-Both 1 & 2
23	Unusual Anesthesia	4-No Records
24	Unrelated E/M service by the same physician during a postoperative period.	1-Medical Records
25	Significant, separately identifiable E/M service by the same physician on the day of a procedure or other service	4-None
26	Professional Component	4-None
32	Mandated Services	4-None
47	Anesthesia by Surgeon	4-None
50	Bilateral Procedure	4-None
51	Multiple Procedures	4-None
52	Reduced Services	1-Medical Records
53	Discontinued Procedure	3-Both 1 & 2
54	Surgical procedure only	4-None
55	Postoperative management only	4-None
56	Preoperative management only	4-None
57	Decision for surgery	4-None
58	Staged or related procedure or service by the same physician during the postoperative period	3-Both 1 and 2
59	Distinct procedural service	4-None
62	Two surgeons	2-Operative Report
63	Procedure performed on infants less than 4 kg	3-Both 1 & 2
66	Surgical Team	2-Operative Report
76	Repeat procedure or service by same physician	3-Both 1 & 2
77	Repeat procedure done by another physician	4-None
78	Unplanned return to operating/procedure room by same physician following initial procedure for related procedure during postoperative period	3-Both
79	Unrelated procedure or service by the same physician during the postoperative period	3-Both
80	Assistant Surgeon	4-None
81	Minimum assistant surgeon	4-None

82	Assistant surgeon when a qualified resident is unavailable	4-None
90	Reference laboratory	4-None
92	Alternative laboratory platform testing	4-None
99	Multiple modifiers	4-None
AA	Anesthesia Services performed personally by anesthesiologist	Not allowed by QCCH
AD	Medical supervision by physician more than 4 concurrent anesthesia procedures	Not allowed by QCCH
AS	PA, NP or clinical nurse specialist services for assistant at surgery	4-None
TC	Technical component	4-None
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	Not Allowed
QX	CRNA services with medical direction by a physician	Not Allowed
QY	Medical direction of one CRNA by anesthesiologist	Not Allowed
QZ		Not Allowed

Multiple Procedure Discount

Quad City Community Healthcare reimbursement of multiple procedures will follow the payment policies and indicators as per the current year National Physician Fee Schedule Relative Value File as published by CMS. For example, CPT's with an indicator of 2 will receive the "standard payment adjustment rule for multiple procedures". The CPT's will be ranked according to weights. The highest weighted procedure will reimburse at 100% of the agreed upon rate while all other CPT's ranked at a less weights will take the 50% multiple procedure discount. The RVU table can be located at www.cms.gov.

Prevailing Policy

For all participating providers with Quad City Community Healthcare, please refer to your Provider Participating Agreement when determining a prevailing policy. Your participating provider agreement will prevail over the QCCH Provider Manual in the event of a conflict or dispute. For clarifications of any policy or provider agreement, please contact customer service.

Rate Calculations When Not On Schedule or Exhibits

Occasionally a procedure will fall to a non specific code within a category when it cannot be otherwise categorized. When this occurs and a non specific code is billed it must be accompanied by a clear description. These codes are not assigned weights therefore several steps need to be taken in order to correctly reimburse the procedure.

1. The code billed to QCCH will be reviewed and compared to the description to determine if another code would have been more appropriately used. In this instance, the claim will be denied requesting the claim be refilled using a more appropriate code.

2. If it is determined there is not a more appropriate code, the claim will be directed to a physician adviser to determine if there is a similar procedure that a weight can be established and rates be calculated according to the fee schedule conversion factor.

3. If there is not a similar procedure to establish a weight, the code will be reimbursed at our standard percentage or percentage of usual and customary until at such time a number of claims are received with this description and an average price can be established. This process would only be used until a new code with weights is assigned to the procedure

Codes that have not been weighted or are not priced on the fee schedule will be handled in the same manor taking every step to ensure the appropriate reimbursement with the following exception. If a code has been assigned a weight since the fee schedule was established the code will be priced at the current published weights multiplied by the conversion factor assigned to the range of codes applicable. If this information is not available then the steps outlined above will be followed.

Occasionally, QCCH may request additional information such as medical records, further procedure description or in the case of HCPC's a package insert may be requested for drugs or DME.

Drugs, immunizations, and biologicals that are not otherwise categorized or has not been assigned an ASP rate, will reimburse at 87% of the current Red Book average wholesale price or 87% of current average wholesale price as listed by the current pharmacy benefits administrator until an ASP calculation is published by CMS.

Sales Tax

Sales tax is not a medically necessary service and not considered reimbursable to a provider. Sales tax should be considered part of the service provided to a member and is included in the contract allowable. These charges are not allowed to be passed on to the member.

Timely Filing

Filing of claims, corrections, claim inquiries and appeals must all be completed within 365 days of the date of service. We request that initial claims filings be within 90 days of the date of service in order for prompt reimbursement for the employer, employees and to our providers. No claim will be considered or reconsidered after 365 days from the date of service.

Provider Claim Inquiry and Appeals Process

Provider Claim Inquiry

Most claim inquiries can be handled by a telephone call to customer service at 800-457-4726. Your customer service representative will assist you with your questions of how claims were processed and initiate a Claim Inquiry. In the event a provider disputes a claim, the provider has 365 days from the date of service to ask for the claim inquiry, submit a corrected claim, submit additional information to aid in the processing of a claim, review of a denied claim or under/overpayment of a claim.

A Claim Inquiry may be submitted by mail by using the Claim Inquiry Form and mailing to:

Quad City Community Healthcare
PO Box 389
Dubuque IA 52004-0389

**Please refrain from submitting Claim Inquiry and Forms to claims mailing addresses.*

Claim Inquiry submitted by mail will need to include a completed Claim Inquiry Form, corrected claim, medical records and documentation to support a corrected claim, medical records and documentation that may need to be submitted for the review of the denied claim.

If your initial claim inquiry does not satisfactorily resolve the claim and you have additional information, please submit a second inquiry with the new information available. Please advise the customer service representative if this is a second inquiry or mark your Claim Inquiry Form as a second inquiry.

Provider Appeal

If you have exhausted the claim inquiry process you may dispute a claim adjudication action by submitting a provider appeal for post service claims only. A provider appeal must be submitted within 180 days of the date on the remittance advice but before 365 days from the date of service using the Provider Appeal Form. The form must be completed and must be accompanied by any medical records and documentation to be considered with the appeal.

A Provider Appeal may be submitted by mail to:

Quad City Community Healthcare
PO Box 389
Dubuque IA 52004-0389

The provider appeal process is not to be used in place of the member appeals process. Members may appeal pre and post service claims under the member appeals process. A member may appoint a provider as an authorized representative to submit a member appeal on their behalf. The provider would then need to follow the member appeal process. Please contact customer service at Quad City Community Healthcare at 800-457-4726 for the plan specific member appeal process.

Credentialing and Recredentialing

General Policy

All providers, practitioners, facilities and ancillary providers must be credentialed by the plan prior to rendering services to member of the plan as per your provider agreement. Contracted providers will be prohibited from balance billing members for services rendered prior to credentialing approval. Providers may not bill incident to another practitioner in lieu of credentialing. Recredentialing will take place approximately every 3 years.

The credentialing and recredentialing policy is designed to protect the membership of the health plan as well as update records accordingly to maintain adequate provider network access, demographics and provider directories.

All participating providers, practitioners, facilities and ancillary providers are required to inform the plan of changes to demographics such as but not limited to practice location changes, remit to information changes, W9 information, telephone and contact numbers. Please also notify the plan when practitioners are no longer practicing under your tax id/group practice.

Professional Liability Malpractice Coverage

As per the contractual agreement with Quad City Community Healthcare, providers must maintain professional liability malpractice coverage insurance at all times not less than $1,000,000 per occurrence and $3,000,000 in aggregate annually.

If at anytime the policy terminates, is not renewed, or is reduced in coverage the provider must notify Quad City Community Healthcare in writing within 10 days of the change.

Medical Services

Case Management Program

The purpose of the Case Management Program is to identify potentially high risk, high cost members and to develop and implement high quality, cost effective care plans. The primary objective is to insure quality, cost effective care through the development of individualized care plans that require effective communication and collaboration with the member, providers, case manager and benefit managers.

Case Management

Quad City Community Healthcare is committed to working in partnership with the member, physician, other providers (i.e. home health and infusion therapy providers), family, and resources in the community. QCCH RN Care Managers will coordinate high quality, appropriate care, in the most appropriate setting, by the most appropriate provider, in the most cost effective manner. Depending on the case, if necessary, the RN Care Manager will do a case review onsite and/or attend patient staffing meetings to assist with discharge planning.

There are several key components of the Case Management program, including health education, care plan coordination, including the use of community resources and discharge planning.

Case identification can occur in several different ways, including, but not limited to: a) during the inpatient UR process, i.e. repeated hospitalizations, chronic disease, compliance monitoring needs, high cost/high risk members, b) high cost specialty services, i.e. transplants, c) abuse/neglect issues, d) end of life care.

Utilization Management Program

Components of Utilization Review will include:

Concurrent Review

Concurrent Review will be performed by RN Care Managers (Nurse Reviewers) to assess the appropriateness of admission and continued stay. This will be accomplished through telephonic review utilizing industry standard criteria, in cooperation with the participating/nonparticipating hospitals UR departments. Discharge Planning and Case Management opportunities will be identified at this time. The frequency of review will be based on the specific facts of the case, including diagnosis and the existence of any co-morbidities that may adversely affect the outcome or length of stay. If necessary, the RN Care Manager will do the review onsite. Any issues identified will be discussed with the attending physician and concerns will be reviewed with the local Medical Director or Physician Advisor.

Preauthorization

Preauthorization is a process for authorizing services on a pre-service basis for a defined list of diagnostic/surgical procedures, durable medical equipment and pharmacy based on approval criteria. Depending on the situation, it may also require additional medical director review as well.

Referral Management

Quad City Community Healthcare will have an in network benefit and open access to all participating providers and an out of network benefit, in the event that a member chooses to seek care outside of the network. In the event that a service is not available in the network, a preauthorized referral will be required to assure that the in network level of benefit is applied.

Quad City Community Healthcare RN Nurse Reviewers may authorize referrals for out-of-network services based on a set of approved criteria/standing orders. When the RN Nurse Reviewer cannot approve the referral, it must be referred to the Medical Director or Physician Advisor for a medical decision to be made.

Decisions will be made in a timely manner. Once all information needed for the review is obtained, a decision will be communicated back to the physician and the member within 24-48 hours during regular business days.

Timeliness of Review Decisions

Quad City Community Healthcare is committed to insuring that medical management decisions are made in a timely manner.

Utilization Review decisions (approvals and denials) will be communicated to Participating Providers with 24-48 hours during regular business days of receiving all of the pertinent clinical information. Written confirmation of the decision will be sent to the member and provider within 2 business days of the decision.

All Utilization Management will be performed by Quad City Community Healthcare Registered Nurses. The address and phone number is as follows:

Quad City Community Healthcare
PO Box 389
Dubuque IA 52004-0389
Ph: 800-457-4726
Secure Fax: 563-587-6556