PARKVIEW
SIGNATURE CARE

PROVIDER MANUAL

Revised January 2018

Table of Contents

Parkview Signature Care PROVIDER MANUAL

INTRODUCTION

Signature Care maintains a complete preferred provider network of qualified medical professionals to meet the diverse needs of our customers. We are pleased to have you in our network of providers.

In 1992, Parkview Health established the Signature Care PPO network to meet the needs of northeast Indiana health plan sponsors. Employees wanted convenient access to quality providers, while employers sought favorable pricing for their healthcare claims. Although these fundamental needs have not diminished, Signature Care has continuously improved its new products and services and expanded its coverage area. Today throughout Indiana, northwest Ohio and southeast Michigan more than 150 hospitals, 18,000 providers and 1,300 ancillary providers are contracted with Signature Care to offer primary and specialty healthcare services.

This manual was established to assist our providers in efficiently serving our members. While we hope we have answered most of your questions, we do understand that other questions or concerns may arise; we encourage you to contact us directly. You can reach Provider Services by phone at (260) 266-5520 or 800-666-4449 or by e-mail at ProviderServices@Parkview.com

Parkview Signature Care PROVIDER MANUAL

GENERAL INFORMATION

Signature Care is a network of healthcare providers located in Indiana, northwest Ohio and southeast Michigan that can be accessed through an employer's self-funded group health plan or a fully-insured carrier. Signature Care is a Preferred Provider Organization (PPO). When an employer chooses Signature Care as its PPO network, health plan participants receive medical services at a negotiated rate from contracted providers. Signature Care is neither an insurance company nor a provider, but a network of contracted providers working in conjunction with an employer's health plan. Because we are not an insurance company, it is important to define our services to our providers.

Parkview Health Plan Services (HPS) administers the Signature Care network by credentialing providers, establishing contractual relationships with physicians, facilities and Physician Hospital Organization (PHO), establishing fee schedules and repricing claims. Hospitals, physicians, and healthcare professionals who have met the credentialing standards are contracted to participate in the PPO network.

An employer group's health plan and benefit design are established by the employer and/or third party administrator (TPA) or insurance company. Therefore, to obtain benefits for a patient, other than Parkview employees, you will need to contact the payor, not Signature Care. The TPA will produce ID cards, assist employers in designing benefit plans, assist providers with benefits and pay claims. The Signature Care logo will always be identified on the member's ID card in addition to phone numbers for benefits, eligibility and Utilization Review.

WHO DO I CALL?

For claim issues, verifying benefits, checking eligibility and Medical Management questions, refer to the back of the member's ID card for the appropriate numbers. In most cases, providers will need to contact the member's TPA for this information. If questions need to be directed to Health Plan Services (HPS) staff, please call:

HPS Customer Service
Toll Free: 1-800-666-4449
Phone: (260) 266-5510
Fax: (260) 266-5504

HPS Provider Services
Phone: (260) 266-5520
Fax: (260) 266-5503

HPS Medical Management
Phone: (260) 266-5545
Toll Free: 1-800-666-6668
Fax: (260) 266-5540

Signature Care Website
http://totalhealth.parkview.com

Signature Care Provider Portal for In-Network Providers
https://signaturecare.parkview.com/iTransact

Parkview Signature Care PROVIDER MANUAL

SIGNATURE CARE LOGOS

Signature Care EPO

This product offers strong steerage to incentivize members to utilize in network services. All Signature Care guidelines will remain the same for Signature Care EPO providers, e.g. claims sent to HPS for repricing, with Customer Service and Provider Service performed by HPS staff. Reimbursement is at the Signature Care contracted fee schedule.

Parkview Signature Care PROVIDER MANUAL

CREDENTIALING

Credentialing is the process that evaluates physicians, hospitals, facilities, dentists and allied health providers. Each applicant has the responsibility of producing timely and adequate information for a proper evaluation of qualifications and for resolving any doubt about such qualifications. Each participating provider must maintain compliance with all criteria in the Credentialing Plan as a condition of continued participation.

Data needed to initiate the Credentialing Process:

- Tax Identification Number
- NPI
- CAQH Number (ensure that Signature Care has been granted access and CAQH status is "Reattestation")
- W-9 form
- Provider/Professional complete name

All providers must be credentialed for Signature Care prior to contracting, either through the HPS Credentials Committee or by a delegated credentialing entity such as a network or PHO. Hospital-based providers (Emergency Room Physicians, Anesthesiologists, Radiologists and Pathologists) are not required to be credentialed by HPS as they are credentialed by the hospital where services are performed. If services are provided outside an accredited Hospital, credentialing of the professional will be required. The HPS Credential Committee must approve the delegated entity's plan. The delegated entity's Credentials Committee must be constructed to meet state and federal requirements for peer review.

RECREDENTIALING

Recredentialing is conducted every three years; see credentialing plan for a list of those providers and requirements.

PROVIDER CHANGES

Timely notification of changes from provider groups is required. Please notify Provider Services as soon as possible with any of the following changes:

- New professional
- Termed professional
- Termed location
- Tax Identification Number
- Phone number
- Fax number
- Address change
- Billing address change
- Professional name change
- Group name change
- NPI

All changes submitted to Signature Care must be in writing. Please complete our Provider Demographic Form and return to Provider Service representative by:

- E-mail at ProviderServices@Parkview.com
- Fax: (260) 266-5503
- Mail to:

  Signature Care
  Attn: Provider Services
  PO Box 5548
  Fort Wayne, IN 46895-5548

REFERRAL AND AUTHORIZATION

Most payors have health benefit plans that include Utilization Management programs. The payor selects the Utilization Management organization. It is important to check the back of the Member's ID card for the name and phone number of the utilization organization contracted to provide these services. Failure to communicate appropriately with the Utilization Management guidelines may affect reimbursement.

CLAIMS FILING

All Signature Care claims are to be submitted to Parkview Health Plan Services (HPS), either electronically or on paper, for repricing.

ELECTRONIC

- Use TKSoftware: Payer ID 35162
- Use Emdeon: Payer ID 35162
- The provider must verify receipt of their 997 file
- Network participating provider may use the provider portal for verification of receipt. (If you don't have access to the portal please contact Provider Services)

HPS has partnered with TKSoftware to offer providers an efficient and less expensive direct electronic claim submission option. Direct electronic claim submissions on a standard 837 format to HPS through TKSoftware is free. If you wish to receive information on TKSoftware, please contact Provider Services at (260) 266-5520 or by e-mail at ProviderServices@Parkview.com.

PAPER

- Send to:
  Parkview Health Plan Services (HPS)
  PO Box 5548
  Fort Wayne, IN 46895-5548
- CMS 1500
- Use black ink
- Send claims flat with no staples
- Supporting documentation must have sufficient patient identifying information
- Documents will be scanned and must be readable by optical character recognition (OCR) software
  - Use Standard business fonts such as Arial or Times Roman
  - Do not artificially insert spaces between characters within a word
- Align information in the appropriate box
- DO NOT hand write on claims or use white out

CLAIMS FILING – continued

KEY INFORMATION FOR CLAIMS FILING

- Insured/Subscriber's full name and address
- Insured/Subscriber's member ID number
- Insured/Subscriber's group number
- Patient's full name, date of birth and address
- Dates and place of service
- Valid ICD-10 codes for all diagnoses treated
- Date/place/nature of occurrence if diagnosis is due to accident/injury
- Valid CPT codes for all services rendered
- Valid HCPCS codes for any medical supplies or equipment
- Valid Revenue/CPT codes on UB04 forms
- Amount charged and quantity of services
- Amount collected from the patient
- Provider name, Tax Identification Number, NPI (group and professional)
- NDC code if applicable
- Coordination of Benefits (COB) payment from the primary carrier

If a claim is submitted without the above information, it may be returned to the provider for completion. Hand written claims with corrections or alterations will NOT be accepted.

FILING PERIOD

- PPO repricing is subject to the payor filing guidelines, but cannot be less than 120 days from the date of service.
- Claims filed after the Employer Group Health Plan timely filing limit will be provider responsibility, requiring a provider write-off.

CLAIMS PAYMENT

Network providers shall accept payment from Payors for covered services in accordance with the reimbursement terms outlined in the Participating Provider Agreement. Payment made to providers constitutes payment in full by payors for covered benefits except co-payments, co-insurance and deductibles. Providers may not bill members for the balance of covered services above the fee schedule reimbursement; however, a member can be billed for non-covered services.

If Provider is aware that a particular service is not a Covered Service and/or is not Medically Necessary and has complied with all other terms of this Agreement, Provider shall be permitted

CLAIMS PAYMENT – continued

to bill Covered Person, provided that Provider, prior to performing the service, informs and obtains the Covered Person's agreement in writing that such services are not covered and that

Covered Person shall have the sole responsibility for all reimbursement to Provider for such service.

Providers will be reimbursed the fee schedule amount no later than thirty (30) business days after the payor receives the clean claim. The payor is required to pay, deny or provide notice within thirty (30) business days from receipt of the claim. If the provider does not receive notice or payment within this timeframe, the provider is entitled to full billed charges and should seek payment from the payor. Provider may bill member for services if the payor fails to pay.

For claims status, please contact the TPA or insurance company on the group health plan ID card. If no card is available, call Signature Care customer service at 800-666-4449 or (260) 266-5510. Please have the date of service, name of patient and/or patient identification number available at the time of the call.

REPRICING MULTIPLE SURGERY GUIDELINES

Surgical procedures that include a 51 modifier will be repriced at 50% of the allowed amount (or the lesser of the actual charge).

APPEALS PROCESS

Participating Providers have the right to file a Complaint at any time for any reason. Complaints regarding a claim dispute are to be directed to the Payor.

MID-LEVEL PROVIDERS

Parkview Health Plan Services (HPS) Credentialing Plan allows credentialing of Mid-Levels. Physician assistants and nurse practitioners will now be collectively known as Mid-Level providers. HPS recognizes Mid-Level providers in the Signature Care network once they have successfully completed the credentialing process. Under HPS credentialing guidelines, Mid-Level providers must have:

- Collaborative Agreement with a participating physician for Nurse Practitioners, Clinical Nurse Specialist and Certified Nurse Midwives.
- Physician Assistants (PA) must have a Supervisory Agreement in writing, where all delegated tasks are outlined by the supervising physician - Indiana Code 25-27-.5-5-2(F).

INCIDENT TO BILLING GUIDELINES

Mid-Level providers will have the option of billing "incident to" the physician when following CMS guidelines. Please reference MLN Matters (SE0441).

COMMONLY USED - MODIFIER GUIDELINES

Mid-Level providers billing for assistant at surgery, using the AS modifier, will be paid at 12% of the allowable fee schedule. Use of 81, 82 and 80 modifiers with Mid-Level providers is prohibited. Mid-Level provider cannot be assistant surgeons, but may assist at surgery.

Modifier 22: 125% of the allowable fee schedule
Modifier 50: 150% of the allowable fee schedule
Modifier 51: 50% of the allowable fee schedule
Modifier 52: 50% of the allowable fee schedule
Modifier 53: 30% of the allowable fee schedule
Modifier 62: 62.5% of the allowable fee schedule
Modifier 80: 16% of the allowable fee schedule

LOCUM TENEN PHYSICIANS CLAIM SUBMISSION GUIDELINES

Signature Care will allow the use of a "temporary" or locum tenen physician by a contracted Physician Group for a period of up to, but not exceeding, ninety (90) days. The locum tenen physician will provide coverage in a contracted physician's absence for the following circumstances, including but not limited to: illness, pregnancy, vacation, continuing education, missionary trips for military duty. Should the locum tenen physician's tenure exceed ninety (90) days, he/she must be credentialed (when applicable) and contracted.

The physician group will submit claim for the locum tenen services using the contracted physician's name in box 31 of the standard CMS1500 claim form. Modifier Q5 or Q6 should be appended to the CPT code in box 24D of the CMS1500 claim form to indicate services were rendered by a locum tenen physician.

ANESTHESIA CLAIM SUBMISSION GUIDELINES