



PARKVIEW SIGNATURE CARE

PROVIDER MANUAL

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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 and northwest Ohio, more than 95 hospitals, 11,000 providers and close to 1,000 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) 373-9080 or 800-666-4449 or by e-mail at ProviderServices@Parkview.com.

General Information

Signature Care is a statewide network of healthcare providers located in Indiana and northwest Ohio 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 PHOs, establishing fee schedules and repricing claims. Only hospitals, physicians and healthcare providers who have met credentialing standards are contracted to participate in the PPO network.

An employer group's plan and benefit design are established by the employer and/or third party administrator's (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 third party administrator will produce ID cards, assist employer 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.

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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

Phone: (260) 373-9100 or 1-800-666-4449

Fax: (260) 373-9004

HPS Provider Services

Phone: (260) 373-9080 or 1-800-666-4449

Fax: (260) 373-9003

HPS Medical Management

Phone: (260) 373-9030 or 1-800-666-6668

Fax: (260) 373-9040

Website

www.ParkviewTotalHealth.com



Signature Care EPO

This product offers strong steerage to in-network providers. Signature Care EPO has very strong steerage to incentivize members to not utilize out of 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.



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Credentialing

Credentialing is the process that evaluates each physician, hospital, facility and allied health provider. 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.

All providers must be credentialed for Signature Care prior to contracting, either through the HPS Credentials Committee or by 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.

The credentialing process may be delegated by contract to another entity. The HPS Credentials Committee will review the entity's Credentialing Plan to ensure compliance with HPS' criteria, policies and procedures. The HPS Credentials 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 at least every two years. Review of ancillary facilities will occur at least every three years.

Provider Changes

Timely notification of changes from providers within their organization is requested. Please notify Provider Service as soon as possible with any of the following changes:

- ❖ New Practitioner
- ❖ New Location
- ❖ Termed Practitioner
- ❖ Termed Location
- ❖ Tax Identification Number
- ❖ Phone Number
- ❖ Fax Number
- ❖ Address

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

- ❖ E-mail at ProviderServices@Parkview.com
- ❖ Fax at (260) 373-9003
- ❖ Mail to:
 - Signature Care
 - Attention: Provider Services
 - PO Box 5548
 - Fort Wayne, IN 46895

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Referral and Authorization

Most payors have health benefit plans that include utilization management programs. The payor selects the utilization management organization. Health Plan Services performs utilization management for many of the payors, however, 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 Payment

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

Electronic Filing

- ❖ Use TKSoftware: Payer ID is 35162
- ❖ Use Emdeon: Payer ID is 35162
- ❖ The provider must verify receipt

Parkview Health Plan Services has partnered with TKSoftware to offer providers an efficient and less expensive direct electronic claim submission option. Direct electronic claim submission 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) 373-9080 or by email at ProviderServices@Parkview.com.

Paper Filing

- ❖ Send to: Parkview Health Plan Services (HPS)
PO Box 5548
Fort Wayne, IN 46895
- ❖ CMS1500 (formerly HCFA) – red and white form
- ❖ Use black ink
- ❖ Send claims flat with no staples

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Paper Filing continued

- ❖ 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

Key Information for Claims Filing

- ❖ Insured/Subscriber's full name and address
- ❖ Insured/Subscriber's social security number or member ID number
- ❖ Insured/Subscriber's group plan number
- ❖ Insured/Subscriber's group number
- ❖ Patient's full name, date of birth and address
- ❖ Dates and place of service
- ❖ Valid ICD-9 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 UB-92 forms
- ❖ Amount charged and quantity of services
- ❖ Amount collected from the patient
- ❖ Provider name, tax identification number and billing address

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

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Filing Period

- ❖ PPO repricing is subject to the payor filing guidelines.

Claims Payment

Network providers shall accept payment from Payors for covered services in accordance with the reimbursement terms outlined in the Participation 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.

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 identification card. If no card is available, call Signature Care customer service at 800-666-4449 extension 39100. Please have the date of service, name of patient and/or patient identification number available at the time of the call.

Appeal 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 and AS Modifier Guidelines

The Parkview Health Plan Services (HPS) Credentialing Plan has been revised to allow credentialing of physician assistants. Nurse practitioners have been credentialed for some time. Physician assistants and nurse practitioners will now be collectively known as mid level provider. HPS recognizes mid level providers in the Signature Care network once they have successfully completed the credentialing process. Under HPS credentialing guidelines, physician assistants must have a supervisory agreement in writing, where all delegated tasks are outlined by the supervising physician (I.C. 25-27.5-5-2(F)).

Mid level providers are required to complete the credentialing process established by HPS. Once this process has been completed, the mid level providers will be expected to bill under their name and Signature Care will reprice the mid level provider's services under the allied fee schedule. Mid level providers will have the option of billing "incident to" the physician when following CMS guidelines.

Effective November 5, 2009, 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 providers cannot be assistant surgeons, but may assist at surgery.

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 no 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 or military duty. Should the locum tenen physician’s tenure exceed ninety (90) days, he/she must be credentialed (when applicable) and contracted.

Locum Tenen Physicians Claim Submission Guidelines (continued)

The physician’s group will submit claim for the locum tenen services using the contracted physician’s name in box 31 of the standard CMS1500 (formerly HCFA 1500) claim form. Modifier Q5 or Q6 should be appended to the CPT code in box 24D of the CMS 1500 claim form to indicated services were rendered by a locum tenen physician.

[Anesthesia Claim Submission Guidelines](#)