

PROVIDER MANUAL

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I. CORPORATE OVERVIEW

Suburban Health Organization

Welcome to Suburban Health Organization. As a member, you have joined a group of physicians and hospitals committed to providing quality health care and service in central Indiana.

Suburban Health Organization (SHO) is a physician and hospital network serving central Indiana. SHO is comprised of nearly 1600 physicians throughout central Indiana and 8 hospital systems. SHO is one of the largest Indiana networks providing managed care services including risk and non-risk contract negotiations, administration of medical management and claim processing functions, and educational support to physician and physician office staff through provider relations. SHO also provides physician recruitment and is a licensed third party administrator.

- A. Through SHO both physician and hospitals retain their own independent status, but work cooperatively on SHO risk contracts and clinical activities.
- B. Physicians are key to SHO's success. Both Specialty and Primary Care Physicians are represented on the SHO Board of Directors.
- C. PHO members include:
 - Boone County PHO
 - Health Link Network
 - Hancock Regional PHO, Inc.
 - Hendricks Physician Hospital Organization, Inc.
 - Morgan County Health Delivery Network, Inc.
 - Riverview Health Network
 - Westview Delivery System, Inc.
 - St. Vincent Care Management Organization (CMO) including St. Vincent Mercy and Putnam County Hospital
 - St. Joseph Health Network
- C. SHO negotiates and manages HMO health contracts for physician and hospital members. Services provided through these contracts include medical management, centralized contracting, claims processing, credentialing, cost utilization reporting, and provider relations.

II. SUBURBAN HEALTH ORGANIZATION MAILING ADDRESSES AND PHONE NUMBERS

Suburban Health Organization
2780 Waterfront Parkway East Drive
Suite 300
Indianapolis, IN 46214

| | | |
|---------------------|------------------------------|--------------------|
| Administration: | 317.692.5222 or 800.570.7816 | 317.692.5233 (Fax) |
| Network Management: | 317.692.5241 or 800.451.3597 | 317.692.5233 (Fax) |
| Credentialing | 317.692.5241 or 800.451.3597 | 317.692.5233 (Fax) |

Cooperative Managed Care Services (CMCS)

M•Plan and Advantage Health Solutions claims submission:

SHO
P.O. Box 502530
Indianapolis, IN 46250

| | | |
|---------------------|------------------------------|---|
| Medical Management: | 317.692.5223 or 800.570.7894 | 317.295.5300 (Fax) 866.269.0503(Fax) |
|---------------------|------------------------------|---|

| | | |
|---------------------------------------|------------------------------|--------------------|
| Customer Service: (Claims Inquiry) | 317.596.5929 or 866.873.4516 | 317.570.6822 (Fax) |
|---------------------------------------|------------------------------|--------------------|

For on-line status, please visit www.cmcs-indy.com and click on “online provider claim status inquiry”

III. APPLICATION AND CREDENTIALING PROCESS

1.0 Eligibility to Participate in Suburban Health Organization

A provider is eligible to be considered for participation in the Suburban Health Organization if:

- A. The provider is an M.D., D.O., D.P.M or D.D.S. (Oral Maxillofacial Surgery)
- B. The provider has clinical privileges at one of the Suburban Hospitals and that his/her clinical privileges are not limited or restricted in any way; and has provided true, correct and complete information in Physician's application for participation in Suburban.

The following providers are excluded from the credentialing process:

- Hospital-based practitioners who practice exclusively within the inpatient setting and who provide care only as a result of members being directed to the facility (such as Anesthesiologists, Emergency Medicine, Pathologists, Neonatologists, and Radiologists).
- Practitioners with exclusive practice in free-standing facilities used for referrals such as urgent care centers, mammography centers, and surgery centers.
- On-call coverage practitioners.

These providers must sign a provider agreement and notify SHO of the pertinent information for claims payment.

2.0 Criteria for Participation: St. Vincent CMO providers (including St. Joseph)

A. CMO and St. Joseph Network Primary Care Physicians

SHO will consider for participation any Primary Care Physician practicing in Family Practice, Internal Medicine, or Pediatrics at any time.

B. CMO and St. Joseph Network Specialty Care Physicians

- a. Providers with staff privileges who are joining a physician practice already contracted with the CMO, or are taking over a practice of a provider leaving the CMO, may join at any time.
- b. In the event that the CMO has a closed specialty panel and is not accepting new providers, applicants will only be considered if:
 1. It is an open contracting period. The Operating Council, on an as needed basis, determines open enrollment.
 2. Or the Operating Council has determined a need for the provider's particular specialty, for example lack of specialty in a geographical area.

3.0 Criteria for Participation: SHO PHO networks: Boone County PHO, Hancock Regional PHO, Hendricks Physician Hospital Organization, Health Link Network (Henry County), Morgan County Delivery Network, Riverview Health Network, and Westview Delivery System. New provider applicants must contact SHO Network Management to initiate the application process.

- A. The provider must have privileges and be in good standing at the PHO hospital they are interested in joining.
- B. The Provider must complete and sign the PHO Participating Provider agreement for their PHO network.
- C. The Provider must be approved by the PHO Board of the hospital they are becoming a member.

4.0 Application Process

New provider applicants must contact SHO Network Management to initiate the application process. After confirming that the applicant meets the above-listed criteria for PHO/CMO participation, a Network Management Representative will forward the applicant's name and relevant information to the Credentialing staff.

For the CMO, the Participating Provider Agreement must also be completed and returned to SHO before the credentialing process begins.

Provider applicants must complete a Council for Affordable Quality Healthcare (CAQH) universal credentialing application and authorize SHO to access the on-line application and required attachments. It is especially important that the CAQH information be accurate and complete, as the information will not only be used for credentialing purposes, but some of it will also be utilized to populate derivative databases and provider directories.

(Council for Affordable Quality Healthcare contact information: www.CAQH.org/cred or provider help desk at 888.599.1771)

Providers will be notified by credentialing staff of deficiencies on completed applications within 30 days of application receipt. Providers have the right to correct erroneous information by updating the CAQH application or submitting additional attachments.

Discrepancies which must be corrected before credentialing can proceed include those related to licensure, DEA/CSR certification, education, training, board certification status, work history and liability claims history. If clarifying information is not received within 30 days of notification, the applicant's file will be considered incomplete, which will be cause for the credentialing process to be halted (or if the provider is being recredentialled, this could be viewed as grounds for termination).

The Credentialing Coordinator will notify the provider concerning the status of the completed application not later than 60 days after initial receipt and every 30 days thereafter until a final credentialing determination is made.

The provider has the right to review his/her file in person at the SHO office. Such review will be done jointly with the requesting provider and the SHO Medical Director or their designee.

5.0 Credentialing Process

- A. SHO's credentialing activities follow NCQA guidelines.
- B. The Credentialing Coordinator reviews the provider's completed CAQH application/attachments and conducts applicable primary source verification to determine compliance with SHO's credentialing standards.
- C. SHO credentialing staff may request additional information, such as information needed to further explain a liability claim or, for providers who are not board certified, an attestation confirming CME completion (25 Category I CME hours per year or 75 Category I CME hours in 3 years).
- D. Completed credentialing files are reviewed by the SHO Medical Director.
- E. Credentialing information is then presented to the Physician Advisory Committee (PAC) for consideration and determination of approval status. Any denial recommendations made by the PAC are referred to the Medical Advisory Committee for action.
- F. All providers whose applications result in a determination to approve participation will be sent an acceptance letter.
- G. All providers whose applications result in a determination to deny or limit participation will be notified of the credentialing standards which were not met and will be informed of the hearing and appeals process.
- H. Upon being approved as a participating provider by PAC, a new provider can access the following materials via our website at www.suburbanhealth.com:
 - SHO Provider Manual
 - SHO Provider Directories
 - Materials for Prior authorization and claims inquiry
 - Review the products and service available by being a member of Suburban Health Organization.

SHO Providers are recredentialed every three (3) years.

IV. MEMBERS RIGHTS AND RESPONSIBILITIES

All health care is based on both scientific principles and human relationships. The member, PCP, and other health care providers are partners in the member's health care. There are certain rights and responsibilities critical to this partnership.

1.0 MEMBERS HAVE THE RIGHT:

- A. To have twenty-four (24) hour access to PCP and if out of town, receive emergency care if necessary.
- B. To be informed by health care provider of information about diagnosis, treatment, and prognosis in a manner that member can understand.
- C. To participate in decisions involving medical care. Member should receive enough information to enable member to make an informed decision before member receives any recommended treatment. The information should include the specific treatment or procedure, any medical alternatives and associated risks, regardless of cost or benefit coverage.
- D. To refuse treatment and to be informed of the probable consequences of their action.
- E. To have on their behalf a guardian, next of kin, or legally authorized person should their medical condition cause you to be incapable of understanding or exercising their rights.
- F. To know the cost of care and treatment and to receive an explanation of members financial responsibility upon request.
- G. To have member health records kept confidential except when disclosure is required by law or permitted by member in writing. Member has the right to review their medical records with Primary Care Physician.
- H. To receive guidance and recommendations for additional medical care when coverage ends.
- I. To be treated with respect and recognition of their dignity and right to personal privacy.
- J. To receive advice or assistance in a prompt, courteous and responsible manner.
- K. To review the criteria utilized to make an adverse decision regarding any services requested but denied by medical management department.
- L. To continue receiving active treatment from member's provider even if the provider's network status changes (i.e. terminates from the network) until the current treatment period ends or up to 90 days, whichever is shorter.

2.0 MEMBER HAS THE RESPONSIBILITY:

- A. To know the benefits and exclusions of member's coverage.
- B. To obtain referral from PCP for any specialty care, before any specialist's appointment are made.
- C. To contact PCP for any necessary after hours care and to obtain referral authorization for those services.
- D. To know how to access care in emergency, urgent, and routine situations.
- E. To express opinions, concerns, or complaints in a constructive manner to the appropriate personnel with health plan or provider network.
- F. To keep scheduled appointments and give adequate notice of appointment delay or cancellation.
- G. To provide, to the extent possible, information that health plan and providers need in order to care for member.
- H. To be honest, complete and accurate when providing information to the medical staff.
- I. To follow the instructions and guidelines given to member by the medical staff and to consider the potential consequences if member does not comply.
- J. To follow the plans and instructions for care that member has agreed upon by their provider(s).
- K. To be considerate of other patients and to be understanding and tolerant if any delays should occur.

V. GENERAL INFORMATION

1.0 Open/Close Panel

Suburban Health Organization must receive written notification* from the Primary Care Physician to open or close his/her panel. SHO must receive a 60-day notification to close a panel to new patients. St. Vincent CMO and St. Joseph Health Network Primary Care Physicians must have at least 150 members to close their panel.

2.0 Patient Dismissal

If the Primary Care Physician makes a decision to dismiss a patient from his/ her practice the patient and SHO must receive a written notification* from the Primary Care Physician. It is recommended that the patient receive written notification via certified mail. The documentation must include the cause of termination. The Primary Care Physician must continue to provide emergency care to the patient for 30-days following the written notification.

3.0 Provider Termination

Suburban Health Organization must receive written notification* from the Primary Care Physician and/ or Specialist to terminate participation within SHO.

A. Primary Care Physician

- a. SHO must receive written notification 90-days prior to the effective termination date.

B. Specialist

- a. SHO must receive written notification 60-days prior to the effective termination date.

**Written notification should be mailed to:*

Suburban Health Organization
Attention: Network Management
2780 Waterfront Parkway East Drive, Suite 300
Indianapolis, IN 46214

Primary Care Physician Responsibilities

The Primary Care Physician (PCP) is responsible for managing all aspects of the member's healthcare.

1.0 Primary Care Physician Access Standards

A. The following SHO's standard for members' access to Primary Care Physicians Services:

- | | |
|--|-------------------------|
| • Emergency: | Immediate |
| • Urgent: | Within 24 Hours |
| • Routine, Non-urgent symptomatic | Within 5 calendar days |
| • Well/preventive care; such as GYN Exams, Health Assessments, Immunizations | Within 30 calendar days |
| • Access to after care use this: | |

The PCP must provide coverage 24 hours, 7 days a week. This may be accomplished through the use of an answering service, answering machine, or on-call physician. For life threatening, emergency situations the member should report to their local PHO hospital emergency room or the nearest emergency room.

B. Only the member's PCP may refer the patient to a specialist. Refer to Part VI for referral requirements.

VI. SPECIALIST OFFICE VISIT REFFERALS

Specialty referrals are no longer required when referring within SHO but outside of your local PHO network. Example: All out of network specialty referrals require prior-authorization.

1.0 Specialty Office Referrals & Prior-Authorization requirements

- A. Referrals are NOT REQUIRED when referring to an in-network SHO specialist within any of the SHO PHO networks.
Example: A Hancock PCP referring to a St. Vincent CMO Specialist is no longer required.
- B. Requests for services or specialty referrals OUTSIDE of SHO will **require a prior authorization**. **Example: A SHO PCP referring to a Clarian specialist.** See Prior Authorization section.
- C. If a Specialist finds that a member needs to be referred to another Specialist, the Specialist must contact the PCP with recommendations.
- D. Annual Well Women exams do not require a referral if services are within one of the SHO PHO networks. See claim section for Catholic code list.
- E. A referral does not guarantee payment if the member is not eligible or the services are determined not to be a covered benefit by the member's plan. Please verify the member's benefits and eligibility by calling Advantage Health Solutions or M•Plan.

VII. PRIOR AUTHORIZATION

1.0 Prior-authorization

- A. For services that require prior-authorization, please see the [Prior Authorization List](#) or visit www.suburbanhealth.com to obtain a detailed prior authorization listing.
- a. If SHO is secondary to any other insurance or Medicare, in-network prior-authorization is not required.
- B. The provider ordering the test or service is responsible for obtaining prior authorization.
- a. Please verify eligibility and benefits from the health plan. Refer to the [Quick Reference Card](#) for member eligibility phone numbers.
 - b. The Utilization Management nurse should be notified for a prior-authorization by calling 317.692.5223, toll-free 800.570.7894 or by faxing to 317.295.5300/866.269.0503 using the [Prior Authorization Form](#).
 - c. The following information is required on the Prior-Authorization form:

| <u>Member/Patient Demographic Information</u> | <u>Requested Service Information</u> |
|--|---|
| Name | CPT - Code |
| Date of Birth | Date of Service |
| Member ID number/Health Plan | Diagnosis |
| PCP | ICD-9 Code |
| PHO | Location |
| | Office Contact Name |
| | Office Contact Telephone Number |
| | Place of Service |
| | Referring Physician |
| | Referring to Specialty |
| | Referring to PHO |

- d. If criteria is met, a prior-authorization number will be entered in the claims system. An approval letter will be faxed to the referring provider, ordering provider, and a letter will be mailed to the member.
- e. If the Utilization Management nurse cannot determine the medical necessity using Milliman Guidelines or other criteria available for the service requested, the Medical Director will review the case and make a determination.
 - Prior to issuing a denial, the Medical Director may discuss the case with the Primary Care Physician, attending physician or other specialists as needed.

- If after the Medical Director's consultation with the physician it is determined not to meet criteria, the services will not be authorized and a letter will be faxed to the PCP, specialist/provider and member.
 - If Medical Director approves prior-authorization, procedures as outlined. See Provider Manual Prior-Authorization section VII, 1.0, B, D.
- C. Specialists may **not** prior-authorize additional visits or services to be provided by another specialist. The PCP should initiate these requests.
- D. **The physician who is ordering the test or service is responsible for obtaining prior-authorization.**
If the patient is seeing a specialist, it is the specialist's responsibility to obtain prior-authorization.
- E. Durable Medical Equipment (DME)
- ✓ Prior-authorization is required for certain devices and supplies. i.e. wheelchairs, hearing aides, and hospital beds.
 - ✓ DME devices over \$800.00 require prior authorization.
 - ✓ Once the device has been issued, supporting supplies will no longer need prior authorization. i.e. CPAP and Diabetic supplies.
 - ✓ Crutches, canes, and walkers no longer need prior authorization.
- F. DME prior authorization changes apply to the Ancillary providers. Please refer to the ancillary listing on the website, www.suburbanhealth.com.
- G. Biotech/ J-Code drugs require prior authorization. Prior Authorization for M•Plan members is administered through Prescription Solutions. A provider may initiate a request via Prescription Solutions (PSI) by calling 800.711.4555, option 1, or by faxing the authorization form at 800.853.3844. Prior Authorizations for Advantage Health Solution members, should be sent to Suburban Health Organization 317.692.5223, toll-free 800.570.7894 or by fax at 317.295-5300 / 866.269.0503 using the prior- authorization form. Please refer to the Drug Prior Authorization list on the website, www.suburbanhealth.com, for detailed information.

2.0 In-Patient Review

- A. All in-patient and observation stays require prior authorization. Emergent admissions will be authorized through the hospital utilization review department and SHO Medical Management Coordinator.
- B. Utilization review nurse will contact SHO Medical Management Coordinator via VoiCert, FAX, or telephonically to provide admission clinical data. SHO Medical Management Coordinator will utilize Milliman Guidelines to determine medical necessity of admission.

- C. If admission/observation stay is medically necessary, the stay will be approved and a prior authorization number along with a call back date will be given to the utilization review nurse.

- D. If admission/observation stay does not meet criteria, SHO Medical Director will review for medical necessity. If approved, a number is provided with the call back date. If not approved, the utilization review nurse will be notified along with the attending physician and denial letters will be generated.

- E. SHO Medical Management Coordinator will be notified of all discharges.

3.0 Out-of-Network Inpatient Hospitalization

The SHO medical management coordinator will follow telephonically on all in-patient out-of-network stays. The PCP will be contacted by the Case Manager to facilitate transfer to the in-network setting as soon as the member is stable.

4.0 Medical Management Criteria

Milliman Guidelines has been approved to determine prior-authorization length of stay, and on an in-patient basis to determine medical necessity. Medicare Guidelines and Health Plan Benefit Interpretations are used when available. Copies of pertinent criteria are available upon request by calling 317.692.5223.

VIII. EMERGENCY SERVICES/URGENT CARE

1.0 Definition of Emergency Services

Emergency Department Services shall mean those medically necessary services required for the alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen medical condition(s) which, if not treated, would lead to further disability, severe pain, or death.

A member does not need to receive prior authorization nor does he/she need to receive emergency medical services from an in-network facility in a situation where a prudent layperson could reasonably believe that his/her condition required immediate medical attention specifically including a member who is experiencing contractions.

2.0 Emergency Services Referral Process

- A. If the member calls the PCP or on-call physician and it is determined that he/she requires emergency medical services, refer the member to one of the in-network emergency facilities.
- B. Prior authorization is no longer required for in-network emergency room or urgent care visits.

3.0 Claims for Out-of-Network Emergency Services

When Suburban Health Organization receives a claim for out-of-network emergency medical services, the following will occur:

- A. The Emergency Department record will be reviewed to determine if the visit was medically necessary and met the prudent layperson rule.
- B. If criteria is met, the Emergency Department visit will be authorized and the claims paid.
- C. If criteria is not met, the ED record will be reviewed by the SHO Medical Director who will determine if the visit was medically necessary or met the prudent layperson rule.
- D. If the Medical Director approves the visit, it will receive an authorization number and the claims will be paid. If the Medical Director determines the visit does not meet criteria, a denial will be placed in the system and appropriate letters and faxes will be generated with appeal rights.

4.0 Urgent Care Services

Urgent conditions are those which require prompt evaluation yet are not considered to be life threatening. Evaluation and treatment may be needed on an urgent basis to control pain or evaluate a condition that cannot wait for PCP management.

A. *Urgent Care visits* follow the *same process as Emergency Care visits*.

IX. CASE MANAGEMENT

1.0 Purpose of Case Management

Suburban Health Organization utilizes Case Management to assure that high quality, cost effective care is consistently provided to patients who require multiple services for an extended period of time.

2.0 Case Management Guidelines

A. Case Management Nurses will consider for Case Management the following types of cases. Cases include, but are not limited to:

- Members identified through Predictive Modeling data that indicates a member needing proactive care management
- Members identified by issue category, e.g.; pharmacy issues, disease state specific programs, very high resource utilization cases.

Examples include:

- Neonatal Intensive Care
- Organ transplant, including bone marrow transplant
- AIDS/HIV
- Severe burns
- Head trauma
- Spinal Cord Injury
- Malignant Neoplasm
- Leukemia
- Chronic conditions requiring extensive services
- Acute inpatient rehabilitation
- Skilled nursing facility

B. Any condition that may be deemed catastrophic in nature can be referred to Case Management.

C. Primary Care Physicians, Specialists, Utilization Management Nurses can refer a member to Case Management.

D. To initiate Case Management assessment, contact Case Manager at 317.692.5223.

3.0 Case Managers will:

- A. Contact and collaborate with the PCP and/or Specialist for the efficient delivery of services.
- B. Monitor the need for continued services and perform all necessary concurrent review.
- C. Coordinate all necessary services so that contracted providers are utilized whenever possible.
- D. Follow the member until goals are met with the patient and/or provider
- E. Work with the In-Patient Case Managers to ensure continuity of care after discharge.

X. MENTAL HEALTH/SUBSTANCE ABUSE

1.0 General Information

Suburban Health Organization *does not* hold the behavioral health risk. M•Plan and Advantage are contracted with other behavioral health providers. Members and Providers should call the appropriate behavioral health provider to initiate care. Mental Health Provider Phone numbers are listed on the member's Health insurance ID card.

Advantage Health Solutions

Midwest Behavioral Health Network
1.800.223.6246

M•Plan

Comprehensive Behavioral Care
1.800.458.6139

XI. LABORATORY SERVICES

1.0 St. Vincent CMO and St. Joseph Health Network In-Office Laboratory Services

- A. Laboratory services do not require prior authorization.
- B. Physician offices may perform laboratory tests in their office as permitted by CLIA exempt status.
- C. A practice owned laboratory may perform services and bill CMCS directly, as long as they accept the CMO laboratory fee schedule and have a CLIA registration.

2.0 Reference Lab Services for St. Joseph Health Network & St. Vincent CMO

- A. Mid America Clinical Laboratories (MACL) provides all clinical laboratory services that cannot be performed in the Provider's office.
MACL will provide the proper requisition forms for CMO specimens.
- B. MACL and St. Vincent Laboratory draw sites may be used for drawing blood.

A list of locations for MACL draw sites can be found on their website

<http://www.maclonline.com>

MACL Customer Service: 317.803.1010

3.0 Pathology for St. Joseph Health Network & St. Vincent CMO

- A. Pathology services do not require prior-authorization.
- B. All outpatient pathology services must be sent to Cytology Pathology Services (CPS) or Ameripath.
- C. Bone Marrow and fine needle biopsies should be sent to St.Vincent Hospital pathology lab.
- D. St. Vincent hospital based pathologists (Ameripath) will provide in-patient pathology services.

- E. St. Joseph Network hospital based Pathology Associates will provide in-patient pathology services.

| | |
|-------------------------------------|---------------------|
| Cytology Pathology Services: | 317.255.3579 |
| Ameripath: | 317.275.8112 |

4.0 SHO PHO Networks In-Office Laboratory Services

Boone County PHO, Hancock Regional PHO, Healthlink Network (Henry County), Hendricks Regional Health, Morgan County Health Delivery Network, Riverview Health Network, and Westview Delivery System.

- A. SHO PHO Network Providers may perform laboratory services in their offices as long as they accept the SHO fee schedule and have a CLIA registration.

5.0 Reference Lab Services for SHO PHO Network

- A. Laboratory services that cannot be performed in the SHO Provider's office should be referred to the local PHO hospital.

XII. RADIOLOGY SERVICES

1.0 Radiology Service Sites for St. Vincent/St. Joseph Health Network

- A. Radiology services may be obtained at any St. Vincent or Northwest Radiology location.
- B. Radiology services may be performed in the Provider's office (where facilities exist) if the patient has been referred to the Provider for an office visit, consultation or procedure.
- C. Provider offices may bill for services and will be paid at the SHO radiology fee schedule.

2.0 Radiology Service Sites for SHO PHO Networks

- A. Boone County PHO, Hancock Regional PHO, Healthlink Network (Henry County), Hendricks Physician Hospital Organization, Morgan County Health Delivery Network, Riverview Health Network, and Westview Delivery System.

PHO's may perform services in the Provider's office (where facilities exist), or at their local PHO Hospital.

3.0 Radiology Prior-Authorization

- A. In general, radiology services do not require prior-authorization. However, refer to the most current Prior Authorization List for radiology procedures that do require prior-authorization. If there is a question regarding the necessity for a radiology prior-authorization, contact a Utilization Management Nurse at 317.692.5223.

XIII. ANCILLARY PROVIDERS

1.0 Ancillary Services

The list of the contracted ancillary providers for the SHO/ St. Vincent CMO/ St. Joseph Health Network is updated on a monthly basis and can be found on the Suburban Health Organization website at:

www.suburbanhealth.com

Refer to this list when requesting prior-authorization.

XIV. CLAIMS ADMINISTRATION (SHO M•Plan & Advantage Health Solutions)

1.0 Submitting Claims

SHO accepts the American Medical Association (AMA) billing form, also known as the HCFA 1500 form or UB92 for healthcare facilities and electronic claims. See [Electronic Claims Submission](#).

A. 120 Day Filing Limit

- a. According to the SHO policy and procedure on claims submission, all claims must be received by CMCS within one hundred and twenty (120) days from the original date of service. If the claim is not received within 120 days of the date of service, the claim will be denied and the provider will not be eligible for payment for the service. Providers may not bill the member.

Claim address: SHO
 P.O. Box 502530
 Indianapolis, IN 46250

- b. If the claim is received after the 120 days filing limit from the date of the service, the claims will be denied. The provider will need to write off the total amount of the claim and the member may not be billed.

If the claim was submitted within the filing limit, but CMCS does not have the claim on file, please submit proof of timely filing with the claim. The provider's office should submit a computer print out of the following information:

- The original date of claim submission (include all previous dates claim submitted)
- Name of insurance plan where claim was originally submitted
- Address where claim was originally submitted

If the provider office uses internal coding for each insurance plan, please submit a break down of the various insurance codes.

B. 180 Day Follow up policy from the Date of the Original Explanation of Payment to Request Adjustment to Claim

- No claim will be considered for an adjustment unless the provider's request is within 180 days from the original EOP. (Explanation of Payment)
- If the provider's request is received within 180 days of the original EOP, an adjustment to the claim will be made if appropriate.
- If the provider's request is not received within 180 days of the original EOP, the claim will be denied. The provider will need to write off the remaining balance and the members may not be billed.

C. Interest Payment Policy - Interest will be applied to all clean claims paid after 45 days from the date received by CMCS.

D. To be considered a clean claim, SHO requires the items listed below on each HCFA claim: If any of these items are missing or in error, the claim may be denied.

| | <u>Box</u> |
|---|------------|
| • Subscriber name and Health Plan I.D. number | 4,1A |
| • Patient name and Health Plan I.D. number & D.O.B. | 2,1A,3 |
| • Employer name and group number | 1,11B |
| • Patient's Health Plan | 11C |
| • Other insurance coverage | 9 A-D |
| • Prior Authorization number/Precertification number | 23 |
| • Diagnosis (ICD-9 code and description) include all five digits | 21 |
| • Provider Name | 31 |
| • Itemized charges | 24 |
| • Date of service | 24A |
| • Place of service | 24B |
| • Procedure code (CPT or HCPCS and description) | 24D |
| • Units (if applicable) | 24G |
| • NPI of rendering physician (after May 23, 2007) | 24J |
| • Tax I.D. number | 25 |
| • Vendor Name & Address | 33 |
| • NPI of billing provider (after May 23, 2007) | 33a |

E. Place of service code

The following place of service codes should be used to indicate where the member received the service or treatment:

| | |
|----|---|
| 11 | Office |
| 12 | Home |
| 20 | Urgent Care facility |
| 21 | In-Patient hospital |
| 22 | Out-Patient hospital |
| 23 | Hospital Emergency Room |
| 24 | Ambulatory Surgical Center Birthing Center |
| 25 | Military Treatment facility |
| 31 | Skilled Nursing facility |
| 32 | Nursing facility |
| 33 | Custodial Care facility |
| 34 | Hospice |
| 41 | Ambulance (land) |
| 42 | Ambulance (air or water) |
| 50 | Federally qualified Health Center |
| 51 | Inpatient Psychiatric facility |
| 52 | Psych facility – partial hospitalization |
| 53 | Community mental health center |
| 54 | Intermediate care facility/ mentally retarded |
| 55 | Res. Substance abuse treatment facility |
| 56 | Psychiatric residential treatment center |
| 60 | Mass immunization center |
| 61 | Comprehensive inpatient rehab facility |
| 62 | Comprehensive outpatient rehab facility |
| 65 | End Stage Renal Disease (ESRD) treatment facility |
| 71 | State or local public health facility |
| 72 | Rural health clinic |
| 81 | Independent laboratory |
| 99 | Other unlisted facility |

II. Obstetric and Gynecologic / Catholic Directive Access

- A. CMCS is a Catholic owned organization and does not process any claims for any services conflicting with the Catholic directives/family planning. Please send all claims for services conflicting with the Catholic directives to the addresses below. If a claim is sent to CMCS, you will receive an EOP with the correct address to mail the claim.
- B. For a complete listing of diagnosis and procedure codes that are considered Catholic Directives, please visit www.suburbanhealth.com to review the [Catholic Directive List](#).

Claim and precertification information for:

| |
|------------------------------------|
| ADVANTAGE Health Solutions: |
|------------------------------------|

Please send all claims for services conflicting with the Catholic directives to:

Cyrca, Inc.
303 Congressional Blvd.
Carmel, IN 46032

Precertification or to verify benefit eligibility (family planning or services conflicting with the Catholic directives) only:

Cyrca, Inc: 317.818.2802- option 8 or 800.510.0225
Fax: 371.575.9370

| |
|---------------|
| M•PLAN |
|---------------|

Please send all claims for family planning or services conflicting with the Catholic directives effective 11-24-03 to:

M-Plan Claims
PO Box 357
Linthicum, MD 21090-0357

Precertification or to verify benefit eligibility (family planning or services conflicting with the Catholic directives) only:

M•Plan: 317.705.3318 or 800.878.8802
Fax: 317.705.3277

Additional M-Plan only information:

- Tubals and vasectomies performed as an outpatient procedure and pregnancy terminations **require precertification.**
- Authorization is **NOT** required for: office visits for contraceptive management, diaphragm fitting and IUD indentation, in-office vasectomy, and semen analysis with a participating provider.

3.0. Reimbursement

A. The physician shall be paid the lesser of the SHO's fee schedule or the physician's usual and customary charge, minus any co-payments, deductibles, coinsurance, and withholds. Contractually, the physician agrees to look only to SHO for payment of the amounts due to them. Authorized co-payments and deductibles should be collected at the time of service in accordance with the SHO rules. Members may not be balance billed.

- Procedures are paid at a set fee schedule based on market research in the Indianapolis area.
- To obtain the fee schedule for your top most frequently used codes, please send or fax your provider fee requests to:

Suburban Health Organization
Attention: Network Management
2780 Waterfront Parkway, Suite 300
Indianapolis, IN 46214
Fax number 317.692.5233
or e-mail your Network Management Representative

B. Withhold

A withhold is put in place to pay for services that cannot be anticipated, such as out of network services or catastrophic illness.

- The fee schedule has a 10% withhold.

An Explanation of Payment (EOP) form will be included with each check. All the information you need to properly credit the patient account will appear on the form.

IV. Customer Service (Claims Inquiry)

To check status on a claim or if you have general claim questions, you may fax a Claim Inquiry Form to 317.570.6822 or 888.616.9979 or you may contact a Customer Service Representative at 317.596.5929 or 866.873.4516.

If you wish to check claim status online, please visit www.cmcs-indy.com and click on "Online Provider Claim Status Inquiry".

V. Written Provider Dispute

- A. A first level dispute may be filed by any physician who receives a denial regarding administrative or medical services, via the [Provider Claim Inquiry Form](#).
- To dispute a timely filing denial or to dispute the amount paid on a claim, the claims inquiry form should be faxed to Customer Service with all pertinent information to justify the appeal.
- B. Should the issue not be resolved to the provider's satisfaction after following the above process, a second level dispute may be submitted in writing or by using a [Provider Claim Dispute Form](#) to:

Suburban Health Organization
Attn: Provider Claim Disputes
P.O. Box 502530
Indianapolis, IN 46250

All disputes should be accompanied by the explanation of payment, a written summary justifying the appeal or by using and any documentation that supports your request. The provider will receive a written response of the dispute decision from SHO if the dispute is denied.

VI. Patient Billing

Providers may not balance bill the patient for the differences between the billed amount and the SHO allowed amount for covered services. If the patient has a co-pay indicated on the ID card, that amount should be collected at the time of service.

Indiana law protects an HMO member from being balance billed. Additional information can be obtained by visiting the website at:

<http://www.in.gov/legislative/ic/code/title27/ar13/ch15.html>

VII. Other-covered Services

- A. Multiple and Bilateral Procedures

Multiple and Bilateral procedures will be processed in the following manner:

- Primary Procedure paid at 100% of the fee schedule
- All other procedures will be paid at 50% of the fee schedule

B. When an office bills two office codes on the same day:

- a. The well visit office code will be paid at 100% of the allowable fee schedule. No co-pay will be applied to a well visit office code.
- b. The sick visit office code, billed with or without the “25” modifier, will be paid at 50% of the allowable fee schedule. The office visit co-pay will be applied to the sick visit office code.

C. Follow up Surgical Visits

- a. SHO will not reimburse for any follow up office visit or consultation billed within thirty (30) days of the surgery.
- b. Follow-up office procedures and radiological exams may be reimbursed after proper authorization has been obtained.

D. Assistant Surgeons

Surgeries requiring the service of an assistant surgeon will be processed as determined by Milliman and Robertson Criteria.

Assistant Surgeons are reimbursed at 20% of the appropriate fee schedule.

E. Nurse Practitioners and Physician Assistants

- a. Nurse Practitioners and Physician Assistants shall bill their services on a HCFA-1500 claim under their name.
- b. Payment will be made to practice name tied to the tax identification number on the claim at 80% of the Physician Fee Schedule less any applicable withhold.

VIII. Capitation

- A. Primary Care Physicians who choose to be paid capitation are paid once a month based on eligibility provided to SHO from the contracted health plans.
- B. The monthly capitation rate is determined by the age, sex and co-pay of each member. (The attachment is gone so I am guessing we do not need this line.)
- C. Enclosed with each monthly capitation payment is an explanation of information on the capitation report. . If you have questions regarding your capitation payments, contact your SHO Network Management Representative at 317.692.5241 or 800.451.3597.
- D. Primary Care Physicians who are paid fee for service, and cover for a Primary Care Physician who is capitated, will receive the assigned PCP's fee schedule. It is the responsibility of the on-call physician to obtain payment for capitated services from the member's assigned PCP.

IX. On-call Policy

In the event that a member is seen by an on-call provider, claims will be processed in the following manner:

A. Primary Care Physicians

- a. Physicians providing call coverage for a Provider will be paid in accordance with the assigned primary care physician fee schedule.
- b. If the covering physician is within the local PHO, an authorization is not required.

B. Specialty Care Services

- a. Out-of-Network specialist on-call for an In-Network specialist will be paid at the in-network fee schedule. Authorization is required for Out-of-Network on-call specialists. Authorization can be obtained by calling Medical Management at 317.692.5223 or 800.570.7894. Prior authorization can also be obtained by faxing the prior authorization form to 317.295.5300 or 866.269.0503 in order to receive reimbursement for services rendered

X. Subrogation Claims

- A. Under the HMO law, a member cannot be billed for services or expected to pay “up front” for care that is covered under his/her medical benefits. The member should be treated for any other medical condition. SHO will subrogate the claim to the automobile insurance carrier. Your office may only collect the member’s co-pay, if applicable, at the time of service.
- B. Claims should be submitted to CMCS and SHO will pursue subrogation. It is imperative that you indicate on the claim that the care provided was an incident related to an accident by utilizing the proper diagnosis code.



XI. Non-Covered Services

If the physician recommends that a covered individual receive a non-covered service, then the physician shall ensure that the covered individual understands that the service is not covered and that the member may be responsible for the cost of the service. The provider may encourage the member to sign a Waiver for Financial Responsibility after fully explaining possible member responsibility to the member. This should be performed prior to any non-covered services being rendered.

Attachment A

SAMPLE M•Plan Card



COMMERCIAL

| | | |
|---|---|--|
| <p>Group #: 00000123 Member#: 00000045601 Issued: 1/01/06 Member: Member Name</p> |  | |
| | | <p>Benefit Copays</p> |
| <p>PCP: SMITH MD, DAVID PCP 15 PCP Phone#: 317-123-4567 SPEC \$15</p> | | |
| <p>Network: (Network Name)</p> | | <p>ER \$100 UCC \$ 35 MH \$ 20 DEDUCT \$200 RX (other copays may apply)</p> |
| <p>MPlan Customer Service Solutions Center 8802 N. Meridian St. Indianapolis, In 46260 317-571-5320 or 1-800-816-7526 www.mplan.com</p> | | |
| | | <p>Provider Information</p> <p>Send Claims to: SHO Claims: PO Box 502530, Indianapolis In 46250</p> <p>Pharmacist Inquires: 800-788-7871</p> <p>Health Care provider Precert: 800-223-3645</p> <p>Hospital Admission (Outside Indiana) 800-675-2605</p> <p>Other Health Care Inquiries 800-675-2605</p>  |
| | | <ul style="list-style-type: none">• Call your PCP if you need medical care.• Out of area urgent care. Call your PCP prior to seeking follow-up care.• Emergencies or life-threatening medical needs. Seek immediate care and contact PCP within 48 hours <p>For provider payment of emergency services or services authorized by the M-Plan PCP</p> |

Attachment B

ADVANTAGE HEALTH PLAN

(2008 SAMPLE ID CARD)

| | | |
|---|--|--|
|  | (1) Benefit Plan | |
| Member Name: John Q Sample | Benefits Copay: | |
| (2) ID #: HP0000000000 | (10) PCP: \$\$ or % | (14) ER: \$\$ or % |
| (3) Employee: John Q Sample | (11) SCP: \$\$ or % | (15) UC: \$\$ or % |
| (4) Group Name: Employer Name | (12) Wellness: \$\$ | (16) Vision: \$\$ (if applicable) |
| (5) Group #: Policy# | (13) RX: \$\$/\$\$/\$\$ (if applicable) | |
| (6) PCP Name: Your PCP | | |
| (7) PCP Phone: (###)###-#### | | |
| (8) Mailing Address for Claims: Network Admin Network_Admin_Address1 City, State Zip | |  |
| (9) EDI Payer ID: | | |

- | | |
|--|--|
| <p>(1) Type of coverage you have. Names may vary.</p> <p>(2) ID #: Your member ID number, which is used for all Member Services inquiries as well as claims payment, billing and processing.</p> <p>(3) Employee: Name of the insured employee.</p> <p>(4) Group Name: Employer group or group you have coverage through.</p> <p>(5) Group #: Group policy number.</p> <p>(6) PCP Name: Primary Care Physician (if applicable)</p> <p>(7) PCP Phone: Phone number (if applicable)</p> <p>(8) Mailing address for claims: The mailing address for medical claims. This address will be used by providers rendering medical services to you.</p> <p>(9) EDI Payer ID: The number used by providers that file claims electronically.</p> | <p>(10) PCP: Office visit copay for your primary care physician.</p> <p>(11) SCP: Office visit copay for a specialist physician.</p> <p>(12) Wellness: Copay for wellness visits (if applicable)</p> <p>(13) RX: Pharmacy / Prescription copay (if applicable)</p> <p>(14) ER: Emergency Room copay (waived if admitted). Copay not applicable if not on your card. If applicable, a deductible will also be applied.</p> <p>(15) UC: Copay for visit to urgent care center.</p> <p>(16) Vision: Vision copay (if applicable)</p> |
|--|--|