



Provider Office Manual

www.ehpservices.com

888-498-9648

Policies and Procedures
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Introduction to



The Manual

This manual has been provided to help you better understand EHP. Use it as an ongoing reference for all your administrative needs related to EHP. We pride ourselves on providing the highest level of service to our Participating Providers (hereinafter referred to as Providers) and Covered Persons (hereinafter referred to as Members or EHP Members), and look forward to working closely with you. If you have any questions that are not answered by this manual, please contact us and we will be happy to answer them.

Corporate Overview

EHP is a Preferred Provider Organization (PPO) with a network of over 49,000 Providers in the state of Pennsylvania. EHP is a product line offered by Significa Benefits Services, Inc. and independent third party administrator located in Lancaster, Pennsylvania.

EHP's goals are to:

1. Maintain a network of outstanding healthcare Providers dedicated to quality, cost-effective care.
2. Provide user-friendly administration.
3. Offer EHP Members choices from a broad range of network primary care and specialty Providers to maximize benefits and reduce out of pocket expenses. Members also receive benefits if they choose to see a non-network provider, although at a reduced level.
4. Remove HMO-type restrictions on referrals to specialists.

The EHP Network

The EHP network is made up of direct contracts in the Lancaster, Berks and York County areas and works through network partnership agreements with Blue Ridge Health Network and InterGroup Services Corporation. The EHP network can be accessed by third party administrators and insurance companies. A full listing of payers and products can be found in **Appendix A**. Other product offerings and additional information can be found at www.ehpservices.com.

Important Phone Numbers and Addresses

EHP Network Services, Credentialing & Provider Relations

888-498-9648 (Toll Free)

717-735-7760 (Local)

717-399-1693 (Fax)

Website

www.ehpservices.com (website)

information@ehpservices.com (email)

Business Correspondence (not claims) address

EHP

PO Box 8737

Lancaster PA 17604-8737

Prenotification/Case Management

Refer to the Member ID card or refer to the listing on **Appendix A** for Payer/Product specifics.

Claim Status/Eligibility/Benefits Questions

Refer to the member ID card or refer to the listing on **Appendix A** for Payer/Product specifics or call EHP at 888.498.9648.

Claim Submission

Member Identification (ID) Cards

EHP Members receive an ID card designating their membership in the network. Possession of an EHP ID card however does not guarantee coverage. Always verify eligibility with the appropriate Payer (see Appendix A). ID cards may vary slightly in appearance, but all contain the following essential information:

- Name of the insured
- Group name
- Group number
- Dependent coverage (Y/N)
- Effective date
- Office visit co-payment (if applicable)
- Claims submission address
- Contact address and telephone number for eligibility, benefit, claims, and network questions
- Contact telephone number for precertification or preauthorization for hospital admission, pregnancy, or other conditions for which notification is required.
- The EHP logo:



EHP highly recommends that you make a copy of the front and back of the Member's ID card and retain it for future reference.

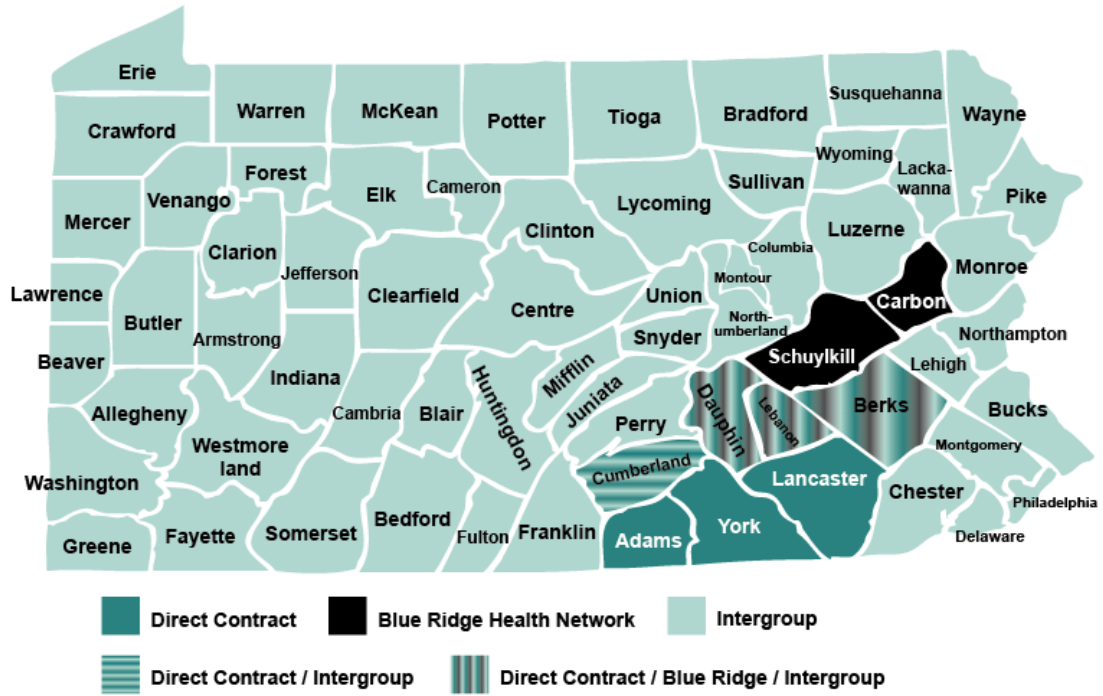
Network Partners/Logos

The EHP network is made up of Providers with direct contracts or those indirectly contracted with EHP through Network Partners. Just as a bankcard displays logos indicating what money access systems you can use, an ID card should include the EHP and appropriate Network Partners logos. In order to access the entire EHP network, a Member needs to have all logos on their Member ID card. As a Provider, in some cases you may have an agreement directly with EHP and with one of EHP's Network Partners listed below. Geography determines which contract takes precedence. Not all employer groups will have access to the entire EHP network. If you have any questions regarding your discounts or contract overlaps please call EHP's Network Services or Provider Relations department.

Network Partner Logos:



EHP Network Partner Coverage Area



Billing Tips

- **Make a copy of the front and back of the Member's ID card.** The ID card contains essential billing information. EHP recommends that you retain a copy of it.
- **You are required to submit claims on behalf of the Member/patient.** Do not ask the Member for payment at the time of service (except for applicable co-payments).
- **Use only printed CMS 1500 or CMS 1450 (UB-04) claims forms.** These standard forms are required to ensure that claims are adjudicated without delay.
- **Send claims to the correct address.** EHP works with several different Payers, each with a unique claims address. Claims should always be submitted to the claims address printed on the Member's ID card.
- **Do not "balance bill" Members for the difference between your billed charges and: 1) the contracted fee amount; or, 2) the amount after discount is applied.** Members are not responsible for the difference between billed charges and the allowable reimbursement. However, Members may be billed for any applicable deductibles, co-insurance or co-payments.

Claims Submission

As stated, EHP works with several Payers (please refer to **Appendix A**). The Payers determine eligibility, benefits and pay the claims. EHP does have a contracted repricing unit but not all claims are submitted through this office. Many payers have EHP fees and schedules loaded into their claim processing systems. It is essential that claims be submitted to the correct address on the individual Member's ID card to avoid payment delay. Remember, the **address for claims submission is clearly shown on the Member's ID card along with an associated EMDEON number for sending claims electronically.**

If the Member's ID card is not available, you can obtain the appropriate contact information by calling EHP Network Services at 888-498-9648 or 717-735-7760.

At the time of treatment, collect any co-payment indicated on the Member ID card from the Member. **Do not balance bill the Member or collect payment for entire service.**

Billing for Services

All claims must be submitted within **90 days** of the date of service.

Services should be billed as follows:

- Professional (physician/provider) must be billed using a printed standard CMS 1500 form. Handwritten forms will not be accepted by the Payer.
- Facility services must be billed using a printed standard CMS 1450 (UB-04) form. Handwritten forms will not be accepted by the Payer.
- To ensure proper adjudication, claims must include the following information:

1500 Field	1450 (UB-04) Field	Information
2	12	Patient Name
3	14	Date of Birth
24A	6	Date of Service
11C	50	Name of Payer/Insurer
11B	61	Name of Employer Group
11	62	Employer Policy Number/Group Number
24D	44/43	CPT Code and Description of Service
21	76	Diagnosis Code Number
11D	50	Coordination of Benefits (COB) Information (as applicable)
24F	47	Billed Charge (Always bill your customary charge, not the EHP fee schedule or discounted amount)
31	1	Provider Name
25	5	Federal Tax Identification Number
33	1	Billing and service address

Surgical Procedure Billing

For reimbursement policies on multiple surgical procedures, bilateral surgical procedures, and surgical trays, contact the appropriate Payer listed on **Appendix A** or the eligibility/benefits number listed on the Member's ID. If the Member's ID card is not available, you can obtain the appropriate contact information by calling EHP at 888-498-9648 or 717-735-7760.

Anesthesia Services

Services involving administration of anesthesia are reported by the use of the five-digit anesthesia procedure code plus patient status modifier. All anesthesia charges are to be reported with time shown as number of minutes. The number of base units is determined by the procedure code.

Facility Fees

Office-based surgical procedure facility charges may be eligible subject to the benefits available under the Member's policy or plan. In addition, EHP must have verified that the office facility has been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC), or the Commission on Accreditation of Rehabilitation Facilities (CARF), or is licensed by the state.

Laboratory Services

Laboratory services should be provided by a participating EHP laboratory. In-network laboratories are available through EHP participating hospitals and stand-alone Provider offices. Reimbursement is subject to the Participating Provider fee schedules.

Sending laboratory specimens to a non-panel facility may result in a reduction of benefits for the Member. Please refer to the EHP Provider Directory for participating laboratories which is available in its most up-to-date format at www.ehpservices.com or call EHP at 888-498-9648 or 717-735-7760.

Explanation of Benefits (EOB)

An Explanation of Benefits (EOB) is generated by the Payer for each claim that is submitted. The EOB provides a description of the disposition of the claim (paid, denied, or pending).

Claim Code Editing

Most EHP Payers use common coding edits and practices for "bundling" or "unbundling" certain billing codes (e.g.: some laboratory services or surgical procedures). For the majority the National Correct Coding Initiative (NCCI) edits are utilized. **IMPORTANT: The Member cannot be billed for balances or procedures which are denied due to coding edits.**

Claims Issues

All questions regarding claims should be directed to the Payer Customer Service phone number listed on **Appendix A**, the EOB or on the Member ID card.

Requesting Fee Schedules

EHP will provide fee schedule or discount information to Providers who are **directly contracted** upon receipt of **written request**. Send your signed request or email to:

EHP - Provider Relations Manager
PO Box 8737
Lancaster, PA 17604-8737

OR

providerrelations@ehpservices.com

The Network

Quality Management

EHP contracted Providers are the cornerstone to our success. We work hard to maintain its quality.

A Medical Quality Management (MQM) Committee, made up of physicians from the EHP network, is available with a goal to maintain quality by:

- Reviewing EHP policy changes involving clinical issues.
- Identifying opportunities for improvement in clinical or administrative areas.
- Evaluating complaints or inquiries from Providers or Members in the network.
- Developing programs to enhance quality and cost effectiveness of medical care.

The Credentialing department also assures the quality of the network by:

- Evaluating Provider applications for inclusion in the network.
- Ensuring that all Providers who are contracted with EHP meet credentialing and current qualification assessments and appointment criteria consistent with managed care standards.
- Evaluating credentialing and re-appointment programs.

Credentialing/Current Qualification Assessment

EHP is a Preferred Provider Organization (PPO). All participating Providers must meet credentialing and re-appointment criteria that are consistent with managed care industry standards. EHP requires the credentialing of all physicians, dentists, optometrists, podiatrists, chiropractors, and behavioral health professionals before including them in the network. Each Provider is then re-credentialed every 2 to 3 years. In some instances credentialing is delegated to responsible parties whose standards are consistent with EHP policy.

In addition, EHP performs or may delegate a current qualification assessment on Physician Extenders, such as nurse practitioners, physician assistants, physical therapists, nurse midwives, and nurse anesthetists who are employed by EHP Providers. Assessments are also repeated every 2 to 3 years.

Initial Credentialing

Physicians seeking credentialing must:

- Have a current unrestricted license to practice
- (If applicable) Be board certified or board eligible
- (If applicable) Have a current and unrestricted DEA certificate
- Have no felony convictions
- Have appropriate malpractice liability coverage.
- (If applicable) Have hospital privileges at an EHP participating hospital

For Providers the credentialing process begins with completion of a standard application. Applications are available from EHP or at the Pennsylvania Medical Society web site www.pamedsoc.org or from the Maryland Insurance Administration web site <http://www.mdinsurance.state.md.us> . In addition to a correctly completed, signed and dated application, the following documents are required:

- Signed and dated Authorization for Release of Information.
- Signed and dated Contract
- Copy of current professional license in the state where the practice is located
- Copy of current DEA certificate.
- Evidence of board certification or eligibility
- Evidence of graduation from medical school (if not board certified)
- Evidence of completion of residency in the proposed specialty (if not board certified)
- Proof of liability insurance coverage (policy face sheet or certificate of insurance which states the policy limits and renewal dates)
- Work history information (this may be indicated on the application or submitted as a Curriculum Vita)

Upon receipt of the documents for non-delegated credentialing, EHP performs a National Practitioner Data Bank (NPDB) query regarding the applicant and requests confirmation of medical staff status from the hospitals where the applicant has stated staff membership. Any information may be subject to primary verification. All information is then evaluated by the Credentialing department for inclusion in the EHP network.

Initial Current Qualification Assessment

EHP also performs current qualification assessments for Physician Extenders such as nurse practitioners (CRNP), physician assistants (PA), nurse anesthetists (CRNA), therapists and nurse midwives. This process is less rigorous than credentialing, but provides a verifiable database that allows Payers to process claims more rapidly and accurately. Physician Extenders seeking a current qualification assessment are required to submit the following documents:

- A completed, signed and dated standard application (available from EHP or at the Pennsylvania Medical Society web site: www.pamedsoc.org or the Maryland Insurance Administration web site <http://www.mdinsurance.state.md.us>)
- Copy of current professional license in the state where the practice is located
- Evidence of board certification or eligibility in the proposed specialty
- Copy of DEA certificate (if applicable)
- Proof of liability insurance coverage (policy face sheet or certificate of insurance which states the policy limits and renewal dates)

All information submitted may be subject to primary verification.

Recredentialing/Repeat Current Qualification Assessment

EHP will recredential applicable Providers every 2 – 3 years. The purpose of recredentialing is to confirm current status of information obtained in the original credentialing process. For non-delegated credentialing EHP will provide the required materials for this process. It is important to complete and return the materials as promptly as possible to avoid disruption in claims payment and possible exclusion from the EHP provider directory.

Current Qualification assessments for Physician Extenders are also repeated every 2 - 3 years.

Delegated Credentialing

EHP may delegate credentialing responsibilities for portions of the network to associated entities, such as participating hospitals or Independent Physician Associations (IPA's), which have credentialing policies that meet EHP standards. It is EHP's policy to regularly monitor the credentialing procedures of these organizations to assure that they continue to meet EHP standards.

Provider Information

To assure and maintain the quality of the EHP network, providers and facilities applying for participation agree to on-site visits. A standard form, provided by EHP, may be completed in lieu of an on-site visit to the office or facility, or information may be obtained from the state specific standard application form. Information requested on site includes:

- Staffing
- Location/Directions
- Office hours
- Telephone numbers
- Fax numbers
- Diagnostic services on-site
- Educational services on-site
- Languages spoken
- Accessibility for disabled persons
- Internet access
- Physical, billing office, and correspondence addresses
- Tax ID number

Some of this information may be recommended to EHP Members seeking specific services. However, as always the selection of a Provider for care rests solely with the Member.

Provider Office Staff Training

EHP believes communication is essential to the success of the network. The network Provider's staff is an important part of that communication. General training sessions are held periodically or when a large number of Providers join EHP at the same time. In addition, EHP's Provider Relations staff will be happy to provide individual training to offices upon request.

EHP sends information regarding changes to the network and administration of the health plans to participating practices as they occur. Important changes are communicated as Provider Alerts found at www.ehpservices.com. Upon receipt of this information, it should be circulated among all physicians and office staff.

Changes in Provider Status

Providers are required to notify EHP within thirty (30) days if any of the following occur:

- Any change in a Provider's medical staff privileges at any hospital, including: probation, modification, restriction, suspension, or limitations of any kind
- Restriction, suspension or revocation of the Provider's DEA certification
- The Provider's exclusion, suspension, or termination from any managed care organization
- Any modification, restriction, limitation, or probation of any kind in Provider's professional license

Providers should also notify EHP immediately of any change in contact information, such as physical or billing address.

Locum Tenens and Other Temporary Providers

EHP should immediately be notified of the employment of any temporary Providers, such as locum tenens physicians. EHP must be aware of the situation to avoid disruptions in claims payments. Locum tenens providers who work for a participating Provider for more than 30 total days in a calendar year are considered part-time Providers and are subject to credentialing policies.

Out of Network Referrals

The EHP network has extensive participating Providers and facilities to treat even the most complex medical problems. **No referrals are required for any visits to Providers within the EHP network.**

If a Member elects a non-participating provider, benefits will be at a reduced level. If there are questions regarding availability of a specific service in any area, refer to the EHP Network Directory, check the EHP web site www.ehpservices.com, or call Network Services at 888-498-9648 (toll-free) or 717-735-7760 (local). Note: Each payer may have a different policy for out of network usage and when it would be considered at the in-network level of benefits.

Pharmacy Benefits

Pharmacy benefits vary by Payer and are administered by a Pharmacy Benefits Management Organization (PBM). EHP has no direct input into selecting PBM's or determining pharmacy benefits. Most PBM services maintain a toll-free number (available on the Member's ID card) and/or a web site with formulary information. There may also be a specialty pharmacy available for injectable medications.

Problem Resolution/Grievance Procedures

EHP is committed to being responsive to the needs of our Members and Providers. For this reason, the following procedures have been established to assist in the resolution of issues and concerns.

Routine questions about claims processing, eligibility, benefits, and related service issues are handled by the Payer, whose contact information is listed on the Member ID card. A complete list of Payers can be found in **Appendix A**.

If service issues cannot be resolved satisfactorily by the Payer's Customer Service staff, they should be brought to the attention of EHP by any of the following means:

- Write to Provider Relations, EHP, PO Box 8737, Lancaster, PA 17604-8737
- Call EHP Provider Relations: 888-498-9648 (toll free) or 717-735-7760 (local)
- E-Mail: providerrelations@ehpservices.com

EHP will work to resolve the issue and will follow up with you regarding the problem.

Appendix A: Payer Listing

Payer	For Eligibility, Benefits & Customer Service	For Precertification, Preauthorization, Prenotification	Claims Address
Significa Benefit Services www.significabenefits.com	800-433-3746 717-581-1300	Sentinel 717-581-1245 800-432-8877 717-581-8841 fax	EHP/Significa Claims EMDEON Number: 23250 1871 Santa Barbara Drive P.O. Box 7777 Lancaster PA 17604-7777
The Loomis Company www.loomisco.com	See ID card General number: 800-782-0392 Fax recall: 610-376-6994	Varies by employer Please see ID Card For information: 800-782-0392	The Loomis Company EMDEON Number: 23223 See ID or P.O. Box 7011 Reading PA 19610
CoreSource www.coresource.com	800-222-1958	Health Care Management 800-480-6658	<p style="text-align: center;">EHP Claims EMDEON Number: 23249 P.O. Box 8377 Lancaster PA 17604-8377</p> <p>To check the status of a pre-pricing claim, after checking with the Payer, please contact sentinel4health at 800-432-8877 or 717-581-1245 Fax 717-581-8841</p>
D.H.Evans www.dhevensassoc.com	800-636-7632 717-671-8551	Please see ID Card For information: 800-636-7632	
Gettysburg Health Administrators/Nippon Life Insurance Co. www.getthealth.com	For Eligibility & CS: 800-497-4474 For benefits: 800-827-4474	Please see ID Card For information: 800-497-4474	
Group Benefit Services, Inc. (GBS) www.gbsio.net	800-638-6085 410-832-1300	800-337-4973	
Managed Benefit Plans, Inc. (MBP) www.managedbenefitplans.com	800-645-1006 800-311-2205	Clinix 800-854-9160	
National Benefits, Inc. (NBI) www.nationalbenefits.biz	800-258-0103	Please see ID Card For information: 800-258-0103	
Self Insured Services Company (SISCO) www.cb-sisco.com	800-457-4726 Ext. 7556	HEALTHCORP 800-457-4726	
Teachers Protective Mutual www.tpmins.com	717-394-7156 800-555-3122	No prenotification requirement.	

Appendix B: Glossary

We realize some words used in the EHP Provider Office Reference may be new to you or used in an unfamiliar way. Here are definitions of these terms as they are used in this reference:

Benefit – Medical services for which the insurance plan will pay, in full or in part.

Claim – A request for payment to the TPA or insurer for care provided to an eligible Member.

Claims Address – The address to which a claim is submitted for payment.

Credentialing – Evaluation of a Provider's professional credentials and competence using primary or secondary sources.

Current Qualification Assessment – Evaluation of the professional credentials of Physician Extenders, such as nurse practitioners, physician's assistants, or physical therapists, who are employed by Providers in the EHP network. Generally, secondary source verification is used, though EHP reserves the right to use primary source verification when indicated.

DEA Certificate – A certificate issued by the Drug Enforcement Administration to physicians and some nurse practitioners allowing them to prescribe or dispense controlled substances.

Delegated Credentialing – Credentialing performed by a facility or organization for the EHP network. Delegated credentialing must meet EHP's credentialing standards.

Facility – An institution, such as a hospital, laboratory, or radiology office, which performs services ordered by physicians.

CMS 1500 – A standardized form developed by CMS for submission of claims by Providers.

Locum Tenens – A Provider who is employed by a participating provider on a temporary basis and does not need to be credentialed. EHP recognizes locum tenens status if the Provider is employed by a participating Provider for 30 days or less per year.

Member – Any individual enrolled in a health benefit plan underwritten and or administered by an EHP Payer and who accesses the EHP network.

Member Identification (ID) Card – The card used to identify an EHP Member, subject to eligibility. This card contains essential co-payment, billing, and precertification information.

National Practitioner Databank (NPDB) – A federal databank containing information on all malpractice judgments, settlements and disciplinary actions against providers since August 1996.

Network – All facilities and Providers that have contracted directly or indirectly with EHP to provide medical services.

Payer – The entity which is contractually obliged to pay for services provided to EHP Members. See **Appendix A**.

Pennsylvania Standard Application – A standard application for managed care credentialing, created and maintained by the Pennsylvania State Medical Society (www.pamedsoc.org).

Participating Provider - A Provider who has contracted with EHP directly or indirectly to deliver medical services to covered persons (Members). The Provider may be a hospital, pharmacy or other facility, or a physician who has contractually accepted the terms and conditions as set forth by EHP.

Preferred Provider Organization (PPO) - An organization which contracts with Providers of medical care. The benefit contract provides significantly better benefits for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons may have benefits for non-participating providers with increased co-payments.

CMS 1450 (UB-04) – A standardized form for submission of facility fees.

Utilization Review – Review of specified medical services in compliance with standards of care.