



Provider Office Manual

www.ehpsignifica.com

888-498-9648

Policies and Procedures

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Introduction to EHP

The Manual

Welcome to EHP, Inc.. This manual has been provided to help you better understand EHP, Inc.'s network product, EHP SIGNIFICA. Use it as an ongoing reference for all your administrative needs related to EHP SIGNIFICA. We pride ourselves on providing the highest level of service to our Participating Providers (hereinafter referred to as Providers in these Policies and Procedures) and Covered Persons (hereinafter referred to as Members or EHP Members in these Policies and Procedures), and we 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, Inc is a Preferred Provider Organization (PPO) whose service area includes much of the state of Pennsylvania. EHP, Inc is wholly owned by AllOne Health Group, Inc., a for-profit subsidiary of Blue Cross of Northeast 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.

EHP offers clients two different PPO network products, EHP and EHP SIGNIFICA.

The EHP Network

The EHP network is made up of direct contracts in the Lancaster and York County areas and works through network partnership agreements with Blue Ridge Health Network in the Harrisburg area, and InterGroup Services Corporation physician and hospital agreements throughout the rest of the state. The EHP network is accessed by a number of different Third Party Administrators (TPA) and an insurance company including CoreSource, The Loomis Company, Erin Group Administrators, and Teachers Protective Mutual. This manual is not focused on the EHP PPO network product. More information can be found about EHP at www.ehpservices.com.

The EHP SIGNIFICA Network

The EHP SIGNIFICA network consists of directly contracted Hospitals and facilities in the Northeast part of the state and in the Lancaster and York county areas, an affiliated state wide physician network, and wrap access to hospitals and facilities throughout the remainder of the state through InterGroup Services Corporation. Valley Preferred providers can ONLY be accessed by members if they have the Valley Preferred logo on their card. EHP SIGNIFICA can only be accessed by Erin Group Administrators, a TPA subsidiary of AllOne), Significa Insurance Group, and other affiliated AllOne companies, these affiliates and/or corresponding products are listed on **Appendix A**. This manual is designed for providers that directly contract with EHP, Inc. for the EHP SIGNIFICA network. The EHP Significa network is the same as the EHP NEPA network these two names should be considered interchangeable.

Important Phone Numbers and Addresses

EHP Network Services & Provider Relations

888-498-9648 (Toll Free)

717-735-7760 (Local)

717-399-1693 (Fax)

Website

www.ehpsignifica.com (website)

Business Correspondence (not claims) address

EHP, Inc.

PO Box 8737

Lancaster PA 17604-8737

Prenotification/Care 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.

Claim Submission

Member Identification (ID) Cards

EHP Members receive an ID card designating their membership in the network. Possession of an EHP SIGNIFICA ID card however, does not guarantee coverage. Always verify eligibility with the appropriate Payer (see Appendix A) . If you are a physician and a member presents with the EHP Significa logo on their card then your contract and reimbursement will be through the state wide physician network, not through EHP, Inc.. These 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 NEPA and EHP SIGNIFICA logos:



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 SIGNIFICA network is made up of Providers with whom EHP directly contracts or who indirectly contract 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 SIGNIFICA 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. If you are a physician and a member presents with the EHP Significa logo on their card then your contract and reimbursement will be through the state wide physician network, not through EHP, Inc. Not all employer groups will have access to the entire EHP Significa network. If you have any questions regarding your discounts or contract overlaps please call EHP's Network Services or Provider Relations department.

Network Partner Logo:



EMPLOYERS SERVICES

EHP SIGNIFICA has established a key strategic partnership with AllOne affiliated TPAs and products. These are described in detail in **Appendix A**.

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 Payer Partners, each with a unique claims address. Claims should always be submitted to the claims address printed on the Member ID card.
- **Do not "balance bill" Members for the difference between the allowable fee schedule or discounted allowances and your billed charges.** 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 and charges for services that are not covered under their benefit plan.

Claims Submission

EHP SIGNIFICA works exclusively with AllOne Affiliates, please refer to **Appendix A** for the appropriate claims address and contact information.

It is essential that claims be submitted to the correct address. Remember, the **claims submission address for each Member is also clearly marked on their Member ID card along with an associated EMDEON number if your practice has the capability of 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.**

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/Product listed on **Appendix A** or the eligibility/benefits number listed on the Member's ID card. 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.

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 in unit values of fifteen (15) minutes each.

Facility Fees

Office-based surgical procedure facility charges are eligible (subject to the benefits of the Member's policy) if EHP SIGNIFICA has 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 SIGNIFICA laboratory. In-network laboratories are available through EHP SIGNIFICA 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 SIGNIFICA Provider Directory (available in its most current form at www.ehpsignifica.com) for participating laboratories or call EHP Network Services 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).

Claims Bundling

Some health benefit plan designs use common coding edits and practices for “bundling” certain billing codes (e.g.: some laboratory services or surgical procedures). The Member cannot be held responsible for balances after claims for these billing codes have been processed.

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 term information to **directly contracted** Providers and facilities who request it **in writing**. Send your signed request to:

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

The Network

Quality Management

The EHP Significa Provider network is the cornerstone to our success and we work hard to maintain its quality.

The Medical Quality Management (MQM) Committee, made up of physicians from the EHP SIGNIFICA network, strives to maintain this quality by:

- Reviewing and approving all EHP policy changes involving clinical issues. Reviewing utilization patterns.
- 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 Committee is also made up of physicians from the EHP network. They assure 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.
- Overseeing EHP's credentialing and re-appointment programs.

Credentialing/Current Qualification Assessment

EHP SIGNIFICA is a preferred Provider network. All participating Providers listed below must meet credentialing and re-appointment criteria that are consistent with managed care industry standards. EHP SIGNIFICA requires the credentialing of all physicians, dentists, optometrists, podiatrists, chiropractors, and behavioral health professionals before including them in the EHP SIGNIFICA network. Each Provider is then re-credentialed every three 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. These assessments are repeated every three years. **Providers contracted through the state wide physician network will be credentialed by the state wide physician network, not EHP.**

Initial Credentialing

It is the policy of EHP to credential all physicians, dentists, optometrists, podiatrists, chiropractors, and behavioral health professionals contracted with EHP and listed in the Provider Directory.

Providers seeking credentialing must:

- Have a current unrestricted license to practice in the state in which the practice is located.
- When applicable be board certified or board eligible in a specialty commensurate with the proposed practice or have completed a residency commensurate with the proposed specialty and supply three letters of recommendation completed by Providers who are board certified in the applicant's specialty attesting to competency in the identified practice area plus a letter of reference from the chairperson of a hospital department in which the applicant is privileged.
- Have a current and unrestricted DEA certificate (if applicable).
- Have no felony convictions.
- Have appropriate malpractice liability coverage.
- Have hospital privileges at an EHP participating hospital (if hospital privileges are applicable).

For Providers practicing in Pennsylvania, the credentialing process begins with completion of the Pennsylvania Standard Application. The application is available from EHP or at the Pennsylvania Medical Society web site (www.pamedsoc.org). Providers practicing in Maryland should complete the Maryland Uniform Credentialing Form, available from the Maryland Insurance Administration web site (<http://www.mdinsurance.state.md.us>) or from EHP. In addition to the correct signed and dated application, the following documents are required:

- Signed and dated Authorization for Release of Information. This form is available on the EHP website, www.ehpservices.com.
- Signed and dated Contract
- Copy of current professional license for the state in which 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).

On receipt of these 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 Committee, which recommends for or against inclusion in the EHP network.

Initial Current Qualification Assessment

It is the policy of EHP to perform current qualification assessments for Physician Extenders such as nurse practitioners, physician assistants, physical therapists, nurse midwives, and nurse anesthetists. 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:

- If practicing in Pennsylvania, a signed and dated Pennsylvania Standard Application (available from EHP or at the Pennsylvania Medical Society web site: www.pamedsoc.org). If practicing in Maryland, a signed and dated Maryland Uniform Credentialing Form (available at the Maryland Insurance Administration web site (<http://www.mdinsurance.state.md.us>) or from EHP
- Copy of current professional license for the state in which 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

It is the policy of EHP to recredential applicable Providers every three 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 three years.

Delegated Credentialing

EHP delegates 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 that information may be obtained from the state specific standard application form. Information requested on the site information form 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 made available 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 on 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. 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 is extensive enough that participating Providers and facilities can usually treat even the most complex medical problems. **No referrals are required for any visits to Providers in the EHP network.**

If Members choose to see a non-participating provider, they may continue to receive benefits, although at a reduced level from what they would have received in-network. If there are questions regarding the availability of a specific service in any area or within the EHP network, refer to the EHP Network Directory, check the EHP web site (www.ehpsignifica.com), or call Network Services at 888-498-9648 (toll-free) or 717-735-7760 (local).

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 pharmacy benefit card) and/or a web site with formulary information.

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: information@chpservices.com

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

APPENDIX A PAYER/PRODUCT LISTING

Erin Group Administrators (EGA)

A wholly owned subsidiary of AllOne, Erin Group Administrators (EGA) is a full-service Third Party Administrator specializing in the administration of group benefit plans for local and regional employers. Their office is located in Lancaster, Pennsylvania. Their website is www.ega-inc.com.

Claim Status/Eligibility/Benefits Questions:

Erin Group Administrators customer service line:
800-433-4736 (Toll Free)
717-581-1300 (Local)

Claims Address:

**EHP/EGA Claims
1871 Santa Barbara Drive
PO Box 7777
Lancaster PA 17604-7777
EMDEON Number: 23250**

Prenotification/Case Management:

Sentinel Management Services, Inc:
800-432-8877 (Toll Free)
717-581-1245 (Local)

Significa Insurance Group

An affiliated company of AllOne, EGA, and EHP, Significa Insurance Group offers fully insured PPO products in Pennsylvania. All claims processing, administration and customer service is provided by EGA.

Claim Status/Eligibility/Benefits Questions:

Significa/EGA customer service line:
800-433-4736 (Toll Free)
717-581-1300 (Local)

Claims Address:

**EHP/Significa Claims
1871 Santa Barbara Drive
PO Box 7777
Lancaster PA 17604-7777
EMDEON Number: 23250**

Prenotification/Case Management:

Sentinel Management Services, Inc:
800-432-8877 (Toll Free)
717-581-1245 (Local)

Appendix B: Glossary

We realize that some of the 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 insurance company 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 within the EHP network. All entities providing 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 verification. This card contains essential co-payment, billing, and pre-notification information.

National Practitioner Databank (NPDB) – A limited-access Federal databank containing information about all malpractice judgments or settlements and disciplinary actions against physicians and dentists 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 hospital and 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 services, with increased co-payments.

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

Utilization Review – Concurrent review of inpatient or intensive outpatient treatment.