Provider Manual

417 Washington Street
Columbus, IN 47201
812-378-7000
www.siho.org
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. <strong>Introduction</strong></td>
<td></td>
</tr>
<tr>
<td>Purpose of this Manual</td>
<td>4</td>
</tr>
<tr>
<td>Overview of SIHO</td>
<td>4</td>
</tr>
<tr>
<td>Health Care Delivery System</td>
<td>4</td>
</tr>
<tr>
<td>Participating Providers</td>
<td>4</td>
</tr>
<tr>
<td>Contact Information</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>II. <strong>Administrative Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td>6</td>
</tr>
<tr>
<td>Billing Members</td>
<td>6</td>
</tr>
<tr>
<td>Paper Claims Submission</td>
<td>6</td>
</tr>
<tr>
<td>Electronic Claims Submission</td>
<td>6</td>
</tr>
<tr>
<td>Resubmitting Claims</td>
<td>7</td>
</tr>
<tr>
<td>Submitting a Corrected Claim</td>
<td>7</td>
</tr>
<tr>
<td>Payment Listing – Remittance Advice</td>
<td>7</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>7-8</td>
</tr>
<tr>
<td>Appeals</td>
<td>8</td>
</tr>
<tr>
<td>Complaints</td>
<td>9</td>
</tr>
<tr>
<td>Credentialing and Re-credentialing</td>
<td>9-11</td>
</tr>
<tr>
<td>Members Information – <em>(Eligibility, ID Cards, Covered Benefits, Requesting a New ID Card, Changes to Member Information, Satisfaction)</em></td>
<td>10-11</td>
</tr>
<tr>
<td>Member Rights and Responsibilities</td>
<td>11-12</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>III. <strong>Primary Care Physicians</strong></td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td>12</td>
</tr>
<tr>
<td>Responsibilities</td>
<td>12</td>
</tr>
<tr>
<td>Panel Status</td>
<td>13</td>
</tr>
<tr>
<td>Appointment Standards</td>
<td>13</td>
</tr>
<tr>
<td>On-Call requirement/Covering Physicians</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>IV. <strong>Specialist Physicians</strong></td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td>14</td>
</tr>
<tr>
<td>Responsibilities</td>
<td>14</td>
</tr>
<tr>
<td>Panel Status</td>
<td>14</td>
</tr>
<tr>
<td>Referrals &amp; Authorizations</td>
<td>14</td>
</tr>
<tr>
<td>Consultation Definitions</td>
<td>14-15</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>V. <strong>Facilities</strong></td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td>15</td>
</tr>
<tr>
<td>Responsibilities</td>
<td>15</td>
</tr>
</tbody>
</table>
VI. Medical Management
Overview
Precertification Guidelines
Therapy Authorization
Durable Medical Equipment
Referral Process
Case Management
Disease Management
Denials & Appeals
Criteria Selection, Updates & Accessibility

VII. Quality Management
Overview
Quality Management Committee
Pharmacy & Therapeutics Committee
Medical Record Guidelines
Medical Records Review
Never Events, Serious Reportable Events, And Hospital Acquired Conditions.

VIII. Preventive Health Benefit Guidelines
Overview
Preventive Health Benefit
Coding for Preventive Health Benefits
Sources

IX. Pharmacy Services
Overview
SIHO Pharmacy Services
Covered Prescriptions
Days Supply/Refills
Pharmacy Prior Authorization
SIHO/CAREMARK Preferred Drug List
Step Therapy Programs

X. Miscellaneous
Electronic Forms
Appendix
Redcard ID Card Sample 27
Explanation of Benefits (EOB) Sample 28-29
Explanation of Payment (EOP) Sample 30-31
Authorization Form 32
SIHO Preventive Health Benefit Guidelines 33-34
Provider Data Sheet 35
I. Introduction

Welcome to the SIHO Network. Medical providers are key to the successful delivery of healthcare for participants accessing the SIHO Network. We encourage your active participation in the SIHO network and invite your inquiries on operational matters.

Purpose of this Manual
This Manual will acquaint you and your staff with the administration of SIHO’s health plans. The manual explains SIHO’s administrative policies and procedures as well as providing information on the various health plans and accounts we administer.

We suggest that this manual be kept available for easy reference. This manual is frequently updated and the most current version is available on our web site: www.siho.org

Overview of SIHO

Background
Southeastern Indiana Health Organization (SIHO) was formed in 1987 as a locally based, health benefit program to effectively manage costs while continuing to assure quality medical care.

Health Care Delivery System
SIHO is a health care delivery system that offers coordinated care through group health benefit programs for fully-insured and self-funded employers. A common feature of all SIHO programs is a coordinated care benefit focusing on certification, concurrent health care review, medical management, and post payment review.

- Fully Insured (Choice Preferred) plans, Prime Care Choice, Care Plus, HRA, HSA, SIHO Secure and CVS/Caremark Plans
  These are managed care products with a traditional set of benefits providing incentives to members to use SIHO participating providers. Members may utilize any participating provider in the network.

- Third party administrator for self-funded; employer sponsored plans:
  These plans are administered by SIHO, utilize the SIHO network access and benefits are paid according to a Summary Plan Description (SPD). Each benefit plan is uniquely designed by the employer. Participants may utilize any participating provider in the network.

Participating Providers
Participating Providers are primary care physicians, specialist physicians, ancillary providers, and facilities who are contracted with SIHO.
Contact Information
A current provider directory, a preferred drug list, and SIHO's preventive health guidelines are available online at www.siho.org.

SIHO also has an Internet Benefit System. This Internet Benefit System has been developed to provide instant access to member eligibility verification, plan benefit information and claims status. If your office has an interest in the benefit system, sign up via the website at www.siho.org. This will allow you to assign your own user id and password. If you have questions or would like to have a training session on the website, you can contact our Provider Call Center.

Provider Call Center
For benefits, claims payment issues, multiple claims on the system, and coordination of benefits call:

(800) 443-2980 Toll Free

Network Services Department
For: Contracting, credentialing, provider education, quality of care issues, Federal Tax Identification Number changes, fee schedules, contract termination procedures, and provider mailings.

(800) 443-2980
Fax: (812) 378-8721

Medical Management Department
For: Certification for hospital admissions, appropriate outpatient services, inpatient & outpatient mental health services and referral authorizations.

Columbus
(812) 378-7070 Local or (800) 443-2980

Provider Disputes
SIHO Network provider participants have the right to initiate a dispute pertaining to issues of professional competency and/or conduct, quality of care, patient safety, and administrative issues. All of these disputes are subject to the participating network agreement between the contracted provider and SIHO Network, LLC.

Providers can send all written disputes to:
SIHO
Attn: Provider Dispute
P.O. Box 1787
Columbus, IN 47202-1787
II. ADMINISTRATIVE PROCEDURES

Overview
Section II of this manual details SIHO’s administrative procedures. The information provided describes claims processing, member billing, SIHO’s responsibilities and provider obligations.

Billing Members
Participating providers may NOT seek payment directly from the member, except for required copayments, deductibles, coinsurance, precertification penalties or any discounted amount above the allowable (negotiated) expense.

Paper Claims Submission
Please note per SIHO’s contract language: if SIHO receives less than 90% of claims electronically from a provider for a period of more than 30 consecutive days, SIHO may adjust provider’s allowed amount at SIHO’s discretion, in order for SIHO to offset any processing expense resulting from receiving paper claims.

Claims submitted by mail should be addressed to:
SIHO
P.O. Box 1787
Columbus, IN 47202-1787

Electronic Claims Submission
SIHO encourages and accepts electronic claims using Payer ID #: 77153. For quicker claims payment and processing, please submit claims electronically.

Not using a clearinghouse?
If your billing system has the necessary functionality you may be able to submit claims directly to SIHO.
- Your system must be able to generate an ASC X12N 837 (004010X098A1) file.
- Your system must be able to split claims by payer so that we only receive claims for SIHO customers.
- Your system must be able to submit both Individual and Group NPI numbers.

Clean Claim Submission
A clean claim is a claim that has all fields required by CMS for both 1500 and UB 04 claim forms completed. A claim will not be considered clean if it is missing any of the required fields or attachments required to adjudicate the claim. To be considered “clean,” a claim must meet the following criteria:
- Have all required fields completed
  a. Paper Claims: Box/field 24j displays the rendering provider (Individual NPI); box/field 33a displays the billing provider location (Group NPI)
  b. Electronic Transactions: NM1 *85 segment contains the Group NPI; MN1 *82 segment contains the Individual NPI
- Not require further investigation by the plan
- Be received within the timely filing period (varies depending on group, please
call SIHO Member Services for groups specific instructions)

- Have all information necessary to adjudicate a claim including any necessary supporting documentation (primary carrier explanation of benefits (EOB), medical records, etc.)

If a claim does not meet all of the criteria listed above, the statutory period for processing will not apply. In some cases, if the information is incomplete or incorrect we will be required to return the claim with a cover letter that will include what is necessary to process the claim.

**Resubmitting Claims**

Prior to resubmitting a claim, check on the claims status through the SIHO website or call the SIHO Call Center. The provider should only resubmit the claim if one of the following is not received within 30 days:

- Payment
- Remittance advice
- Letter requesting additional information
- Any other form of notification from SIHO regarding the status of a submitted claim

**Submitting a Corrected Claim**

- HCFA 1500- Indicate “Corrected Claim Submission” on the claim or provide a cover letter to indicate the claim is a revision of a previous submission.
- UB 04—Indicate the appropriate bill type on the claim.

**Payment Listing—Remittance Advice**

The SIHO Remittance Advice form explains the payment or denial on each claim that was submitted by the provider and processed by SIHO. Sample Payment Listings are on pages 26 and 27.

**Coordination of Benefits (COB)**

Coordination of benefits is a provision in an insurance plan that guarantees each responsible insurer (when a patient is covered under more than one plan) pays only its own portion of claims and prevents double recovery of claims.

Coordination of benefits also designates the order in which multiple carriers pay benefits. The following is a list of definitions used when coordinating benefits. Note that self-funded employer sponsored plans may have specific rules for their member benefit plan. The listed definitions are standard industry guidelines.

- **Birthday Rule**
  
The Birthday Rule is a guideline used by SIHO to identify the primary and secondary benefit plan for a child of parents who are not divorced or separated.

  This guideline as established by the National Association of Insurance Commissioners (NAIC) defines the benefit plan of the parent whose birthday falls earlier within a calendar year (month and day) as the child’s primary benefit plan. The child’s secondary coverage is determined by the benefit plan of the parent.
whose birthday falls later in the year. For example: if the mother of the child has a birth date of 5/17 and the father of the child has a birth date of 8/21, the primary benefit plan for the child is the mothers. The secondary coverage is the fathers.

- **Medicaid**
  The Medicaid Medical Assistance Program (Title XIX of the Social Security Act) provides matching funds to states to help provide medical care and services for the lower income persons. Once Medicaid has been billed, the provider must accept the reimbursement rate as payment in full and cannot bill the recipient or an insurer for the balance.

- **Medicare**
  Medicare is the Federal Health Insurance Program (Title XVIII of the Social Security Act) for people aged 65 years and older and those with certain disabilities. Medicare is composed of two parts: Part A (Hospital Inpatient Insurance) and part B (Hospital Outpatient and Medical Insurance).

- **SIHO Primary**
  SIHO Primary means the member’s first source of insurance coverage is his/her SIHO health plan. Primary coverage is determined by the SIHO Coordination of Benefits specialist.

- **SIHO Secondary**
  SIHO Secondary means the member has other health insurance, which is considered before SIHO coverage.

- **Standard COB**
  Standard COB means SIHO processes the balance on the claim after the Primary’s benefit has paid. Charges paid will not exceed what SIHO would have paid if primary.

- **Benefit less Benefit COB**
  Benefit less Benefit COB means SIHO processes the claim using the member’s SIHO benefit and then subtracts their primary benefit. If the primary carrier’s benefit is greater than or equal to the SIHO benefit, no excess payment will be made. If the primary carrier’s payment is less than the SIHO payment, then additional payment may be made based on the eligible amount and the plan design.

**Appeals**

A provider or facility may initiate an appeal of issues related to the pricing or reimbursement of covered services as priced and outlined in the contract. For any issues not related to pricing or reimbursement, SIHO utilizes a separate appeals process for appeals of adverse benefit determinations per the member’s summary plan description and any other applicable rules/laws. SIHO will work to ensure that the provider or facility is notified during and allowed to participate in this separate process to the extent permitted by the applicable plan document.
A written appeal of a contractual issue on behalf of the provider or facility may be submitted to the Appeals Coordinator at the address identified in the “Provider Disputes” information located in Section 1. A response to such an appeal will be issued to the provider within 30 days.

For those appeals that concern non-contractual issues and relate to adverse benefit determinations, the provider must first ensure that it has the proper authority to represent or otherwise act on behalf of the member. Once confirmed, a written appeal should state the reason(s) for the provider’s dissatisfaction with the original decision. Any additional information or supplementary information that the provider or facility wishes to have considered should also be submitted with the appeal.

Appropriate medical and non-medical staff will consider initial appeals. If the decision rendered by the committee is unsatisfactory to the provider or facility acting on behalf of the member, in certain situations the provider or facility may request in writing a second level, or External Review, appeal.

Providers can send all appeals that are non-contractual in nature and relate to adverse benefit determinations to:

SIHO
Attn: Appeals
P.O. Box 1787
Columbus, IN 47202-1787

**Complaints**

SIHO recognizes that providers may encounter situations in which our operation does not meet their expectations. When this happens, the provider is encouraged to contact SIHO.

SIHO will promptly consider all complaints by its providers. Complaints are classified by SIHO into three categories:

- Administrative complaints: such as claim payment issues, balance billing, benefit applications etc.
- Medical complaints: such as denial of a referral, denial of certification.
- Quality of Care complaints: such as appropriateness of care, continuity of care or refusal of care.

The Medical Management Department addresses medical complaints. The Quality Management Department evaluates and resolves quality of care complaints. Administrative complaints are routed to the appropriate department. Complaints are resolved in a timely manner at the department level.

If the resolution of a complaint is unsatisfactory to the provider, he/she may file a written appeal. The written appeal should state the reason(s) for the provider’s dissatisfaction with the original decision. Any additional information the provider wishes to have considered should be submitted with the written appeal.
Credentialing and Re-credentialing of Providers

SIHO credentials (either in-house or by delegation) its participating providers to verify their professional qualifications. In 2014, SIHO began the process to become URAC accredited. Since then, SIHO’s credentialing policies have been updated. SIHO continues to use CAQH (Council for Affordable Quality Healthcare) for all credentialing activities. No longer is it necessary to complete multiple credentialing applications by hand. New physicians as well as other health care providers joining the SIHO Network may complete the CAQH credentialing application online to begin the initial credentialing process.

CAQH is free to providers, eliminates completing numerous credentialing applications by hand, and reduces paperwork. The CAQH DataSource provides a fast and easy way for physicians and health care providers to securely submit their credentialing information to health care plans and networks by entering their information just one time into the CAQH database.

If you are adding a physician to your practice, contact our Provider Call Center at 800-443-2980 or by email provider.services@siho.org.

Once the provider application has been reviewed, our Credentialing Staff complete the Primary Source Verification process to verify education, licensing, and board certification where applicable. If the application is incorrect or missing information, the provider will be contacted and corrected information must be completed within 15 days. The completed application and subsequent information are sent to SIHO’s Quality Management Committee for final approval before the provider is deemed in-network.

All providers who meet the proper requirements will be credentialed within 90-180 days of the receipt of completed application and notified of final approval/disapproval within 10 days of determination. SIHO ensures the confidentiality of credentialing information.

SIHO continuously monitors in-network provider credentials and reserves the right to terminate or suspend a provider from the network if the provider ceases to comply with network criteria. SIHO may re-credential any participating provider within the scope of the network as often as every three years or otherwise required by any applicable standards.

If you have a question about the Credentialing Policies or the status of a Credentialing application, please contact our Provider Call Center at 800-443-2980 or by email provider.services@siho.org. You can also log in to our Provider Portal at www.siho.org.
FAQs

How does my practice add a physician to become an In Network provider with SIHO? SIHO requires all Participating providers to complete a CAQH Credentialing application. Contact our Provider Call Center at 800-443-2980 or by email at provider.services@siho.org

How long does the SIHO credentialing process take? Once the CAQH application is verified as complete, the provider should be credentialed within 90-180 days. Applications without quality of care discovery review issues will process in 90 days. Applications with quality of care discovery review issues will process in 180 days.

When is my provider due to re-credential with SIHO? SIHO maintains the ability to re-credential providers every 3 years if applicable. The re-credentialing date of a provider is 3 years from the date the provider’s credentials are entered into our system.

Member Information

Member Identification
SIHO reimburses providers only for medically necessary/appropriate-covered services rendered to eligible members. Please note that the Member ID Card does not guarantee member eligibility. Members may terminate their coverage with SIHO without surrendering their card. A copy of SIHO’s current ID card template is attached on pages 26-27.

Member Eligibility
Questions about member eligibility are available on the SIHO web site www.siho.org or Columbus
(812) 378-7070 Local or (800) 443-2980
Fax: (812) 378-7048

Member ID Card
Each covered member receives an ID card with the SIHO logo. Members are responsible for carrying their SIHO ID cards with them at all times. In order to receive benefits, members are to present these cards to their health care providers when they obtain medical services.

Covered Benefits
If there is a question as to whether the service or care is a covered/limited benefit, visit the SIHO web site or call the Call Center at the above (Member Eligibility) numbers.

Requesting a New Member ID Card
If a member has not received or has lost his or her Member ID Card, please direct the member to contact the SIHO Call Center (see Section One, Page 2).
Changes to the Member Information
The member is responsible for reporting all changes of member information to his/her employer and/or SIHO. Changes in dependent information include such events as a new spouse, a newborn child or an adopted child. The addition of a newborn child, as a dependent to a member, is to be completed within 30 days of the date of the birth. If a SIHO member informs you of such a change, please direct the member to his/her employer.

Member Satisfaction
SIHO responds promptly to the concerns of our members. In our effort to continuously improve the quality of services offered to members, questions and concerns are gathered and analyzed to identify areas where improvements can be made. One of the methods we use to gather information is the annual Member Satisfaction Survey.

When services do not meet the member’s expectations, he or she may initiate a complaint or appeal by following the procedures outlined in his or her Summary Plan Description.

Member Rights and Responsibilities
When enrollees join SIHO they have the following rights and expectations:

- Members have a right to receive information about the managed care organization, its services, its practitioners and providers and member’s rights and responsibilities.
- Members have a right to be treated with respect and recognition of their dignity and privacy.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to voice complaints or appeals about the managed care organization or care provided.
- Members have a responsibility to provide, to the extent possible, information that the managed care organization and its providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed to with their practitioners.
- Members enrolled in Prime Care/Prime Care Choice (or any other PCP based plan) have the responsibility to select their primary care physicians (PCP) from among SIHO’s participating primary care physicians. The PCP in those plans will provide, arrange or coordinate all care received by the members.
- Members have a right to reasonable access to necessary and appropriate medical services.
- Members have a right to express a complaint or appeal as outlined in the Member Complaint/Appeal Policy, and to expect a response within a reasonable period of time.
- Members have a right to call SIHO whenever they have a question about the plan or their benefits. The member shall first direct such questions to the SIHO Provider Call Center.
All SIHO members have the following responsibilities:

- To read their Summary Plan Descriptions provided by their employers. They are subject to all of the terms, conditions and limitations and exclusions in the Summary Plan Description.
- To always present their SIHO identification cards when obtaining health services.
- To inform SIHO of any additional health insurance their family may have so that payments can be properly coordinated between SIHO and the other insurer.
- To accurately report the circumstances as to the reason for medical services such as injury from an automobile accident or worker’s compensation.
- To cooperate with their health professionals and follow their advice for treatment of injuries or illnesses once given understandable rational details as to the nature of treatment reasons for prescribed care and consequences/alternatives.
- To keep scheduled appointments or, if necessary, call to cancel appointments as early as possible.
- To pay participating providers the copayments that apply to the care they receive at the time of service.
- To promptly notify their employer and/or SIHO regarding changes in eligibility.

III. Primary Care Physicians

Overview

SIHO Primary Care Physicians are defined as physicians who specialize in Family Practice, General Internal Medicine, General Pediatrics, and OB/GYN. Some SIHO plans require members to select a Primary Care Physician. The Primary Care Physician provides, or coordinates, or is actually aware of all aspects of the member’s health care and history. This section details the responsibilities of the primary care physician.

Responsibilities

The responsibilities of the primary physician include:

- Providing primary care services to members
- Maintaining centralized medical records for applicable members
- Coordinating all aspects of members’ health care
- For some SIHO plans make referrals to appropriate participating providers, ancillary services and facilities
- Providing 24-hour coverage with appropriate call coverage arrangements to ensure that health care services are available to members in the primary care physician’s absence
- Meeting SIHO’s credentialing/re-credentialing requirements
- Following SIHO’s Utilization Management/Quality Management guidelines and adhering to its policies and procedures
- Notifying SIHO of changes in address, licenses, liability insurance or any other issue that could affect his or her ability to render medical care
- Participating in and supporting SIHO’s products, procedures and other delivery system requirements
- Contributing to SIHO’s improvement and accomplishment of its goals and mission by voice, written word and committee involvement in a cooperative, collaborative manner
Please note: Primary care physicians shall not discriminate or differentiate in the treatment of members based on race, color, gender, age, religion, national origin, health status or source of payment.

Panel Status
Unless otherwise notified, SIHO will consider the practice to have an open panel status. If at any time, the practice no longer accepts new patients, please contact SIHO to have the panel status updated.

Appointment Standards
<table>
<thead>
<tr>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting time for adult physical examination</td>
</tr>
<tr>
<td>Waiting time for child physical examination</td>
</tr>
<tr>
<td>Waiting time for semi-urgent care visits</td>
</tr>
<tr>
<td>Waiting time for urgent care visits</td>
</tr>
<tr>
<td>Average waiting time to see physician from appointment time</td>
</tr>
</tbody>
</table>

On-Call Requirement/Covering Physicians
Primary care services must be available to SIHO members 24 hours a day, 7 days a week. When the primary care physician is unavailable, it is his or her responsibility to arrange coverage for SIHO members. The covering physician should report calls and services to the member’s primary physician.

Covering physicians, whether participating or not, must adhere to all administrative requirements and agree not to bill the member for services other than the copay, deductible, coinsurance or to the extent as defined in the member’s benefit plan. It is the physician’s responsibility to explain SIHO’s applicable billing, referral and certification requirements to the covering physician.

When a covering physician sends a claim to SIHO, covered services will be reimbursed at the rate contracted with the primary care physician at the time the services were rendered.

IV. Specialist Physicians

Overview
This section discusses the responsibilities of the SIHO Specialist Physician.

Responsibilities
Contact with the primary care physician should be maintained throughout the Specialist Physician’s treatment of the member. In some SIHO products, such communication is required.

Specialists are responsible for the following:
- Meeting SIHO’s credentialing/re-credentialing requirements
- Following SIHO’s Utilization Management/Quality Management guidelines and adhering to its policies and procedures
• Notifying SIHO of changes in address, licenses, liability insurance or any other issue that could affect his or her ability to render medical care
• Participating in and supporting SIHO’s products, procedures and other delivery system requirements
• Contributing to SIHO’s improvement and accomplishment of its goals and mission by written word and committee involvement in a cooperative, collaborative manner
• Informing members that approved referrals are necessary for maximum benefits

Panel Status
Unless otherwise notified, SIHO will consider the practice to have an open panel status. If at any time, the practice no longer accepts new patients, please contact SIHO to have the panel status updated.

Referrals and Authorizations
Specialists are responsible for helping members understand that for maximum benefits a SIHO approved referral is required. In requesting or arranging for a referral, it should be noted that members may be referred for “Consultation Only” or for Consultation and Treatment.” The definitions of each are:

Consultation Only
Includes taking the patient’s medical history, conduction of an examination and medical decision making. The depth of the consultation will range from problem focused history taking/examination and straightforward decision making to comprehensive history taking/examination and complex decision making.

Consultations include any diagnostic testing ordered by the specialist to make a medical decision. If additional testing or treatment is required, then those services must be requested by the primary care physician or an additional referral for “consultant and treatment” must be obtained.

Consultation and Treatment
In addition to the definition of a consultation (above), treatment involves follow-up by the specialist based upon the result of his/her medical decision making to include:

• Subsequent visits
• In office therapeutic and/or surgical procedures
• Surgical procedures – outpatient
• Requesting precertification for the following services – physical therapy, occupational therapy, speech therapy, home health, durable medical equipment, inpatient confinements, selected outpatient surgeries, orthotics, outpatient psychiatric treatment
• Invasive diagnostics

In addition, specialists who perform services under EITHER referral type are accountable for the following:
• Referring a member back to his or her primary care physician prior to sending the member to another specialist.
• Obtaining authorization from SIHO for specified non-emergency inpatient and outpatient covered services and understanding that the authorization does not guarantee payment.
• Informing members that referrals are necessary for maximum realization of their benefits.
• Communicating the nature, scope and results of the “consultation only” or “consultation and treatment” to the primary care physician. This is considered a vital part of the continuous two-way dialogue regarding a member’s health care.

V. Facilities

Overview
Facility is defined as a party which includes any persons employed by such facility and any persons or entities that provide Covered Services to Covered Persons under such facility’s tax identification number. The term includes affiliates of any Facility that provide Covered Services to Covered Persons which may have a unique tax identification number, but which the Facility either owns or controls.

Responsibilities
Facility will provide services in accordance with the terms of the contractual Agreement.

Work Stoppage
In the event of a work stoppage at Facility, Network agrees to work with the Participating Providers to defer elective admissions, and Facility agrees to cooperate with Network in using its best efforts to provide continuity of care to Covered Persons who have been admitted until normalization of operations at Facility.

Disaster or epidemic
In the event of any major disaster or epidemic, Facility agrees to render COVERED SERVICES insofar as practical according to its best judgment, within the limitations of those facilities and personnel which are available.

VI. Medical Management

Overview
The purpose of the Medical Management Program (MMP) is to ensure that members receive the clinically necessary and appropriate care (including frequency of service and duration) in the right setting; the care is cost effective; and the care results in improved functional, clinical and financial outcome, all while following the client specific summary plan document, and local, state and federal guidelines.

Managed Care responsibilities include, but are not limited to, precertification, referral, determination of medical necessity, steerage to in-network services, evaluation of protocol compliance and Case Management.
Precertification Guidelines
Precertification ensures that a high quality, cost effective and medically necessary method of treatment has been selected for a member’s illness. In most cases, Precertification occurs prior to services being rendered, but retro-authorizations are also processed when a prior authorization is not an option.

Important Note:
The following services require Precertification for most of SIHO’s health plans:

1. Inpatient Admission
2. Outpatient Mental Illness or Disorder, or Substance Abuse Treatment
3. Durable Medical Equipment purchase in excess of $750
4. Rental of all Durable Medical Equipment
5. Home Health Care
6. Hospice Care
7. Selected Outpatient Surgical Procedures (A current list of Outpatient procedures requiring Precertification can be obtained from the SIHO Precertification Department)
8. Physical, Speech, Occupational Therapy

Precertification needs are plan specific. Contact the provider call center for specific requirements.

To obtain Precertification, the Covered Person or the Physician must provide SIHO's Medical Management Department with the appropriate medical information prior to obtaining the proposed services. Please call:

Columbus
(812) 378-7070 or (800) 443-2980

Generally, if a SIHO Network Physician is seen, he/she will obtain the necessary Precertification from SIHO. The required information may be sent to:

SIHO
P.O. Box 1787
Columbus, IN 47202
Fax: (812) 378-7054

For elective medical, surgical, Durable Medical Equipment or Psychiatric Care, the information must be received by SIHO at least one (1) working day before medical services are received. In the case of an emergency admission the Covered Person, or someone acting on his/her behalf, must provide the appropriate information to SIHO within forty-eight (48) hours of the event, or as soon as the Covered Person’s medical condition permits.

If Precertification is not obtained, the member may be subject to a benefit reduction if the benefit is covered at all.

If the admission, service, or equipment requiring Precertification is not approved, the member or the physician may request a review of the case. Upon presentation of
evidence of extraordinary circumstances or medical information justifying the admission, which was not available at the time of the initial request for Precertification, SIHO will certify that portion of the admission of service which is justified.

Important Note: Precertification does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all of the terms of the Plan.

Outpatient Therapy Authorization; Physical, Speech, Occupational Therapies, Chemotherapy, Radiation Therapy, Renal Dialysis

The following guidelines apply to most SIHO plans. Consult the member’s Summary Plan Description (SPD), SIHO call center or www.sihoo.org for benefits that apply to your patient.

When a physician (either the patient’s primary care physician or a specialist with an approved authorization for consultation and treatment) orders therapy for the patient, the ordering physician must write a prescription for the service. The prescription will allow the member to receive an evaluation plus twenty therapy sessions within five working days to allow time for completion of authorization for speech therapy. Mental Health Individual therapy requires prior authorization upon completion of the fifth visit with submission of treatment plan. All therapies do require a script that is submitted to SIHO MM at the time therapy begins.

If the member needs additional sessions, the therapy provider must send SIHO (FAX or MAIL) a copy of the ordering physician’s prescription and a treatment plan. This must be done prior to the last therapy session in order to ensure continuity of treatment. Once this information is received, SIHO will determine the necessity for further treatment within three (3) working days. Written notification of approval or denial will be sent to the therapy provider, member and ordering physician.

Failure to precertify services will cause the claims to be denied and no payment will be made to the therapy provider. If this occurs, the therapy provider may submit medical documentation supporting the need for the additional therapy sessions to the SIHO Health Services Department. If appropriate, the claims will be reopened and processed according to the member’s benefit plan.

Durable Medical Equipment

The ordering physician or his representative may call SIHO Health Services for authorization of durable medical equipment which is of an urgent or emergent need. For non-emergent needs, please submit a signed prescription or DME request to SIHO. SIHO will review the information for medical necessity and written notification will be sent to the durable medical equipment provider, ordering physician and member.

Remember: Durable medical equipment should be ordered by either the patient’s primary care physician or a specialist with an approved authorization.
SIHO’s definition of Durable Medical Equipment is equipment that can withstand repeated use; is generally not useful to a person in the absence of sickness or injury and is appropriate for use in the home.

**Referral Process**
- The PCP must fax, phone or mail the referral request to SIHO when a referral is required by the plan to a specialist – either network or out of the network. If services are available within the network, an out of network referral will be denied.
- The PCP needs to specify the number of visits and the required service in as much detail as possible.
- All routine referral decisions are made within two business days, one business day for urgent, and within two hours for emergencies.
- A referral authorization does not guarantee payment. Reimbursement for services is subject to member eligibility and benefit coverage at the time the service is rendered.

**Case Management**
The Plan provides for special handling of catastrophic and long-term care cases. This feature is designed to assure that care is provided in the most appropriate and cost effective care setting. Case Management is a cooperative effort between the member, the Physician, the member’s family and SIHO. It also allows SIHO to customize benefits by approving otherwise non-covered services or arranging an earlier discharge from an inpatient setting for a patient whose care should be safely rendered in an alternate setting. Case Management clinical staff can make onsite visits at the facility to facilitate quality outcomes and be a liaison for the member, the patient and the providers. That alternate care setting or customized services will be covered only when arranged and approved by the Plan.

**Disease Management**
Members with a chronic illness such as heart disease or diabetes, account for a very high proportion of healthcare dollars and services. Employer groups could opt to enroll in the disease management program and the plan provides for a focused effort of resources into the management and education of the member in programs designed to improve their health and reduce costly and tragic complications associated with their chronic illnesses.

If a member has an illness that falls into one of SIHO’s Disease Management Programs, the member may receive specialized educational materials regarding this illness from time to time. A member may be contacted by mail, the telephone or electronic means to participate in meetings or programs designed to improve their health. SIHO may use one or more of its Business Associates to perform these functions. To the extent permitted by law, a listing of names, addresses and phone numbers may be shared with SIHO’s Business Associates. These lists will be maintained with the strictest of confidentiality as required by law and will not be used or sold with the intent of solicitations or for any purpose outside the scope of Disease Management.

The Disease Management program is a cooperative effort of the Covered Person, his or her Physician, SIHO and its Business Associates.
Denials and Appeals

- In the event a medical service is not approved, the process requires that the member is notified in a timely manner of the reason for the denial.
- A member whose referral or certification request is not approved has the right to appeal such adverse determination in accordance with SIHO’s appeal procedure.

SIHO's CRITERIA OR GUIDELINES INCLUDE BUT ARE NOT LIMITED TO:

- McG (Milliman): Healthcare Management Guidelines
- National Institutes of Health
- Health Care Financing Administration
- Hayes Directory
- American Academy of Otolaryngology
- American Academy of Family Practice
- American Academy of Pediatric
- FDA
- NQF
- SIHO's Clinical Guidelines established by and reviewed biennially by the Quality Management Committee (QMC)

Review criteria are available onsite and when permitted by license, will be distributed on request. Criteria are reviewed annually to ensure that the most recent versions are being used and are approved.

VII. Quality Management

Overview

The Southeastern Indiana Health Organization (SIHO) Quality Management Program (QMP) strives to improve the quality of health care and administrative services offered to members, physicians and employers. It does so through the establishment of a formal process and an infrastructure for continuously monitoring, evaluating and improving the health care and administrative services provided under all managed medical products. SIHO places great emphasis on the QM process because it is the organization’s desire to assure that the quality of clinical and administrative services provided to SIHO members is continuously improving.

Quality Management Committee (QMC)

The committee is comprised of six physicians (four primary care and two specialists) and three hospital representatives. Functions of the QMC include but are not limited to:

- Provide oversight of SIHO quality management activities, with recommendations for improvement, as appropriate.
- Provide support and recommendations to the Medical Director, as necessary.
- Establish systematic, ongoing monitoring and evaluation processes to identify opportunities for improvement.
- Establish medical policy.
- Maintain disease management protocols.
- Oversee and approve credentialing and re-credentialing activities.
Medical Record Guidelines
SIHO’s medical record guidelines were developed and approved through the Quality Management Committee. The goal of these guidelines is to improve the quality of documentation in medical records. SIHO requires that individual medical records be maintained for each member according to accepted professional guidelines, which include that records are current, dated and have the provider’s signature.

All information in the medical record and information received from physicians, practitioners and health facilities must be kept confidential.

Each office must have established policies to assure that the medical records are complete, promptly filed and safely retained in accordance with acceptable professional practices and state statutes. SIHO expects that patient confidentiality will be practiced by every provider.

General Guidelines
Medical record documentation must include the following:

- Patient’s name and ID #
- Patient’s biographical data
- Allergies or absence of allergies noted
- Significant illnesses and medical conditions are indicated on a problem list.
- Past medical history is identified and includes serious accidents, operations and illnesses.
- The history and physical examination documents appropriate subjective and objective information for the presenting complaints.
- Documentation of informed consent for applicable procedures or treatment where appropriate.

All entries should be:

- In ink
- Legible
- Signed
- Dated

Each visit must be documented in the medical record to support the diagnosis and to justify the treatment. Documentation for a visit should include the following:

- Date of visit
- Chief complaint or purpose of the visit
- Pertinent vital signs
- Objective findings
- Diagnosis or clinical impression
- Studies ordered, such as laboratory or x-ray procedures
- Therapies administered
- Disposition, recommendations and instructions to members
- Referrals to specialists or therapy practitioners
- Signatures or initials of practitioners, practitioners’ names and professional designation (such as MD, DC, DO, DPM, RN)
• Advanced directives or documentation of discussions regarding advanced directives, when appropriate.

Follow-up
Notes should indicate follow-up care, telephone calls or visits. A specific time for the follow-up should be noted in weeks, months or as needed.

Follow-up documentation should indicate:
• Adverse clinical findings
• Unresolved problems from previous office visit.
• If a consultation had been requested, there is a note from the consultant
• Results of studies ordered should be filed in the chart and initialed by the primary care physician to signify review.
• Discharge summaries include condition at time of discharge and post-operative instructions given to the patient.
• Emergency care

Health Education and Preventive Services
Health education, preventive services, recommendations and wellness counseling should be clearly noted and incorporated in the progress notes or in a specially designated section.

These services should be documented as applicable:
• For patients 14 years and over, smoking cessation and alcohol or substance abuse.
• Immunizations
• Pap smear
• Breast exam and/or mammogram
• Digital rectal exams

Medical Records Review
The objectives of the medical records review are:
• To evaluate the structural integrity of the medical record.
• To evaluate ambulatory medical record documentation for the presence of information that conforms to good medical practice which includes continuity and coordination of care and is necessary to provide quality care.
• To evaluate compliance with preventive health care guidelines as designated by SIHO.

Never Events, Serious Reportable Events, and Hospital Acquired Conditions
SIHO reviews inpatient claims to identify eight specified hospital-acquired conditions, as defined by the National Quality Forum. SIHO does not pay hospitals for additional inpatient days that directly result from the condition beyond the expected length of stay or that result in a preventable admission. Patients likewise are not responsible for payment.
In addition, the health plan and its members do not pay any charges related to three never events\textsuperscript{2} or for a set of eight\textsuperscript{3} serious reportable events, also defined by the National Quality Forum.

If a never event or a serious reportable event occurs, SIHO requires hospitals in its network to notify the health plan, along with at least one of three designated patient safety organizations: The Joint Commission; the state reporting program for medical errors; or a patient safety organization such as a state-specific patient safety center.

SIHO’s Quality Management Department reviews all identified never events and serious reportable events and follows up with individual facilities. Facility representatives must identify root causes of never events and serious reportable events, and the must identify changes to improve patient care systems and processes. Facility representatives must communicate with patients and their families when these events occur.

\textsuperscript{1}The eight specified hospital acquired conditions, as defined by the National Quality Forum, are as follows: (1) unintended retention of a foreign object in a patient after surgery or other procedure; (2) hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products; (3) failure to identify and treat hyperbilirubinemia in neonates; (4) a burn incurred from any source while being cared for in a healthcare facility; (5) intravascular air embolism that occurs while being cared for in a healthcare facility; (6) medication error; (7) a fall while being cared for in a healthcare facility; and (8) deep vein thrombosis and/or pulmonary embolism following certain orthopedic procedures: total knee replacement and hip replacement.

\textsuperscript{2}The National Quality Forum defines a “never event” as “errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a real problem in the safety and credibility of a healthcare facility.” For purposes of this policy, SIHO defines the following events as never events: (1) surgery or invasive procedure performed on the wrong person; (2) surgery or invasive procedure performed on the wrong side or body part; (3) performance of the wrong surgical or invasive procedure.

\textsuperscript{3}SIHO will not pay facilities for a set of eight serious reportable events, as defined by the National Quality Forum: (1) unintended retention of a foreign object in a patient after surgery or another procedure; (2) patient death or serious disability associated with a hemolytic reaction due to administration of incompatible blood or blood products; (3) patient death or serious disability associated with an electric shock while being cared for in a healthcare facility; (4) intraoperative or immediately post-operative death in an ASA Class I patient; (5) patient death or serious disability associated with use of contaminated drugs, devices, or biologics provided by a healthcare facility; (6) death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates; (7) any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances; and (8) patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.

\textbf{VIII. Preventive Health Benefit Guidelines}

\textbf{Overview}

This section details SIHO’s preventive health benefit guidelines. The information provided describes policy benefits and elements of periodic health evaluation visits.
Preventive Health Benefit
The Preventive Health Benefit, in general, is intended to cover exams, immunizations, and diagnostic testing for non-high risk, asymptomatic patients. Therefore, it represents suggested testing for patients who present with no additional complaints and are not high risk. The tests, immunizations, and exams indicated on the benefit grid are covered at 100% when administered within the appropriate time frame for those members who have SIHO’s Preventive Health Benefit.

Remember: Not all SIHO plans include the Preventive Health Benefit as a part of the health care benefit.

Coding for Preventive Health Benefits
When additional, medically appropriate, tests are indicated for patients who present for a preventive health exam but have other complaints and/or family history that would indicate the need for additional testing, the physician should submit an appropriate ICD-9 Diagnosis Code in addition to the preventive health V-Code. If additional testing is done without medical documentation, the patient may be responsible for the charges. Please have your office staff let patients know when they may be responsible for such charges.

Sources
Organizations whose standards are used in developing and updating the preventive health benefit include the American Academy of Family Practice Standards, the American College of OB/GYN Standards, the Center for Disease Control Recommendations, the American Cancer Society Recommendations, the American Academy of Pediatric Standards, and the US Preventive Services Task Force Recommendations.

IX. Pharmacy Services

Overview
This section provides a summary of the SIHO Pharmacy Procedures and is designed to assist you and the member’s Pharmacy in filing claims for services rendered to SIHO members. Most of the plans administered by SIHO use CVS/CAREMARK Prescription Services as the Pharmacy Benefits Manager. Always check the current ID card of the patient to confirm the appropriate Pharmacy Benefits Manager vendor to be used.

SIHO Pharmacy Services
Since 1/1/99, SIHO prescription services have been provided through CVS/CAREMARK Prescription Services. CVS/CAREMARK operates the nation’s largest independent Prescription Benefit Management (PBM) program, providing cost-effective prescription drug benefits to members, retirees and members of funded benefit plans. More than 1000 clients including corporations, unions, employer coalitions, federal and state agencies, insurance companies, and managed care organizations use CVS/CAREMARK for their prescription benefit services.

Pharmacies are able to conduct the following transactions on-line:
  • Member Eligibility verification
• Drug pricing information
• Deductible/co-pay/co-insurance calculations
• Coordination of Benefit determinations
• Drug interaction analysis
• Automatic claim filing with SIHO

Covered Prescriptions
• Drugs which by Federal Law require a prescription and have received FDA approval for the intended use
• Insulin and insulin syringes
• Compounded medications that include at least one Federal Legend Drug or State Restricted Drug in a therapeutic amount
• Drugs covered under member benefits

Days Supply/Refills
Maximums will vary among the specific SIHO plans. Typically, 34 is the maximum number of days that a prescription may be filled at retail and 90 for mail order. These maximums will vary among the specific SIHO plans.

Pharmacy Prior Authorization
SIHO requires certain drugs to have prior authorization or a letter of medical necessity.

Some of the most common drugs requiring prior authorization are:
• Retinoids for patients after age 31
• Contraceptives (if excluded by the health plan) may be approved, if needed for a medical condition
• Biotech or specialty medications such as: Synagis and Enbrel
• Erectile Dysfunction medications such as: Viagra, Cialis

It is important to submit the prior authorization at the time the prescription is written so that a member’s prescription is not denied when being filled at the Pharmacy. Telephonic requests are processed the same day they are received. All requests are processed within 24 hours. The drug prior authorization form is included at the end of this section.

Once the proper form is completed you may fax or mail it to SIHO. Please see Section I page 3 for additional information.
SIHO/CAREMARK Preferred Drug List
The SIHO prescription drug benefit program’s goal is to provide quality pharmaceutical care at lower costs. As a means of controlling costs, SIHO encourages its physicians to prescribe drugs on the SIHO/CAREMARK preferred drug list. Prescribing preferred drugs helps keep drug costs down thereby enhancing the performance of risk based plans. Allowing substitution of generic products is encouraged when appropriate. Questions about the preferred drug list should be directed to the Network Services Department.

The SIHO/CAREMARK Preferred Drug List is included in these materials and is available on the SIHO web site @ www.siho.org

Step Therapy Programs
Some SIHO health plans use pharmacy step therapy programs, which require members to try generic or preferred brand medications before being allowed to use non preferred brands. Both the applicable member and physician will receive advanced communication about such programs before they are effective.

X. Miscellaneous

Electronic Forms
SIHO.org offers a number of electronic forms available for your convenience. There you can find anything from forms dealing with credentialing all the way to Provider data sheets. These forms and more are found in the provider section of the SIHO website, specifically http://www.siho.org/Forms/
# How to Read Your EOB (for members) and EOP (for providers)

## Sample EOB

![Sample EOB Image](image-url)

## Explanation of Benefits

**Confidential: Contains Protected Health Information**

**THIS IS NOT A BILL**

### Member Service:

- **Subscriber Name:** JOE SAMPLE
- **Member ID No.:** 0006
- **Group ID:** 111111
- **Processed Date:** 07/14/2014
- **Patient Name:** JOE SAMPLE

### Claim Details:

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Code</th>
<th>Description</th>
<th>Service Dates</th>
<th>Benefit</th>
<th>Exp Code</th>
<th>Exp Amount</th>
<th>Deductible Amount</th>
<th>Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/22/2014</td>
<td>0320</td>
<td>ER Consult</td>
<td>06/22/2014</td>
<td>$160.00</td>
<td>5.34</td>
<td>$60.00</td>
<td>$0.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>06/22/2014</td>
<td>0450</td>
<td>ER Consult</td>
<td>06/22/2014</td>
<td>$875.00</td>
<td>5.12</td>
<td>$700.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Total Column Totals:**

- **Billed Amount:** $975.00
- **Adjusted Amount:** $165.00
- **Paid Amount:** $780.00
- **Plan Pay:** $0.00
- **Non-Covered:** $0.00
- **Other Insurance Paid:** $0.00
- **Total Plan Pay:** $504.00

### Explanation Codes/Description:

1. **$70.00 was applied for liability $12000 Form Calendar Year OOP.**
2. **$70.00 was applied for liability $6000 Ind Calendar Year OOP.**
3. **$80.00 was applied for liability $12000 Form Calendar Year OOP.**
4. **$80.00 was applied for liability $6000 Ind Calendar Year OOP.**
5. **$70.00 copay was applied for liability $150 ER Facility Capay.**
6. **$80.00 copay was applied for liability $150 ER Facility Capay.**

### Plan Status:

- **Plan Expert:** MIDWEST ABC REGIONAL HOSPITAL
  - **Paid To:** 170134
  - **Check #:** 03/17/2014

**Update 1/20/2017**

28 | Page
**Appeal Rights**

**IMPORTANT NOTICE CONCERNING YOUR COVERAGE**

Benefits and eligibility will change from time to time. Be sure to use the most recent Summary Plan Document (SPD) to read any special notices about your coverage. Do not rely on outdated information.

**Appeals Procedure**

If you disagree with the decision on your claim, you (or your authorized representative) may file a written appeal within the timeframes allowed under your Plan, generally within 90 days of the denial of your claim.

Upon your request, you are entitled to receive, free of charge, copies of all documents, records and the identity of medical or vocational experts consulted by the Plan in determining benefits. In lieu of copies, you may be given reasonable access to the documents.

Your appeal must give the reason(s) you believe the claim was improperly denied, and include any additional relevant information or documents in support of your appeal. Failure to file a timely appeal may prevent you from any further review of the benefit decision in State or Federal Court of Law. Send your appeal to: SIHO Insurance Services, PO Box 1787, Columbus, IN 47202-1787.

The Plan will notify you of the decision on your request for review no later than 90 days from the date your request is received. If you receive an adverse decision following your appeal, you have the right to bring a Civil Action under Section 502(a) of ERISA. Please consult the Summary Plan Description (SPD) for more information about the appeal procedures. Your SPD can be viewed online at: www.sho.org. Select Member Login and enter your unique, sign-on information.

**You Should Know**

How to Read Your EOB can be found at www.sho.org by clicking the FAQ Link.

To access your complete Summary Plan Document (SPD), access the SIHO member portal at www.sho.org. Once logged in, click on My Benefits and then Plan Information on the drop down box.

**Go Green**

Get paperless for your Explanation of Benefits (EOB) online. When you go paperless, you will receive email notifications when an EOB is posted to your account. You can view, print and download an EOB any time. There is no cost for this service. You simply sign into the SIHO member web portal at www.sho.org. Go Green today!

---

**How To Read EOB**

1. **Explanation of Benefits (EOB)**: When and how you pay your deductible, coinsurance, and copayments.
2. **Service Date**: The date in which the provider rendered the service.
3. **Provider**: The provider who rendered the service.
4. **Benefit Code**: The benefit code that was used to determine the amount that the benefit will cover.
5. **Benefit Description**: This section provides additional information regarding the procedure that was performed.
6. **Claim Number**: The claim number associated with the service.
7. **Benefit**: The benefit that was applied to the service.
8. **COPAY/OVER BILL**: The amount that the member is responsible for paying.
9. **Coinsurance**: The percentage of the benefit that the member is responsible for paying.
10. **Deductible**: The amount that the member must pay before the benefit begins.
11. **Out-of-Pocket**: The total amount that the member is responsible for paying.
12. **Out-of-Pocket Limit**: The maximum amount that the member is responsible for paying.
13. **Net Total**: The total amount that the member is responsible for paying after all benefits have been applied.
14. **Explanation Code/Description Tab**: This section provides a complete listing of all the services provided.
15. **Verdict**: This section provides a complete listing of all the services provided.
16. **Budget Details**: This section provides additional information regarding the services provided.
17. **Payment Details**: This section provides additional information regarding the services provided.
18. **Commentary**: This section provides additional information regarding the services provided.
19. **Contact Information**: This section provides additional information regarding the services provided.
20. **Go Green**: Provides step-by-step directions on where to find the ‘How to Read EOB’ documentation.
### Explanation of Payment

**Patient:** JANE SAMPLE  
**Provider:** PROVIDER GROUP INC  
**Group:** GROUP NAME

<table>
<thead>
<tr>
<th>Claim #:</th>
<th>Provider Group Inc</th>
<th>Procedure Code</th>
<th>Qty</th>
<th>Billed Amount</th>
<th>Adjusted Amount</th>
<th>Exp Code</th>
<th>Allowed Amount</th>
<th>Claim Amount</th>
<th>Net Covered</th>
<th>WH1</th>
<th>DBC</th>
<th>Net + WH1</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/21/2013</td>
<td>78610</td>
<td>$225.00</td>
<td>$225.00</td>
<td>$100.75</td>
<td>$100.75</td>
<td></td>
<td>$100.75</td>
<td>$100.75</td>
<td>$100.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/22/2013</td>
<td>78619</td>
<td>$245.00</td>
<td>$245.00</td>
<td>$100.75</td>
<td>$100.75</td>
<td></td>
<td>$100.75</td>
<td>$100.75</td>
<td>$100.75</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Vendor Totals

<table>
<thead>
<tr>
<th>Billed Amount</th>
<th>Allowed Amount</th>
<th>Claim Amount</th>
<th>Net Covered</th>
<th>WH1</th>
<th>DBC</th>
<th>Net + WH1</th>
</tr>
</thead>
<tbody>
<tr>
<td>$580.00</td>
<td>$580.00</td>
<td>$580.00</td>
<td>$580.00</td>
<td>$580.00</td>
<td>$580.00</td>
<td>$1,160.00</td>
</tr>
</tbody>
</table>

---

**Explanation Code/Description:**

- 010 SEE TRANS APPENDIX / DEDUCTIBLES/COVERED/COINS APPLIES

---

**Appeal Rights:**

- Contact us at (cTollFreePhone) or (cLocalPhone)
- Visit us at our website: (cWebAddress)
1. Provider Service: If you have questions, please call us at the toll free number listed at the top of your Explanation of Payment. Our friendly and knowledgeable representatives are here to assist you.

2. Service Dates: Represents the date in which the patient was treated and the date in which you are submitting charges.

3. Procedure Code: This section is to determine what procedure was performed.

4. Billed Amount: This is the billed amount before any negotiated adjustments, co-pays, deductibles or any ineligible amounts.

5. Adjusted Amount: This amount will indicate any reduction or increase in benefits payable.

6. Exp. Code: This code is used to explain the reason for an adjustment, deductible, copay, or coinsurance.

7. Allowed Amount: The amount remaining before any non-covered, deductible, or copayment amounts have been subtracted from the amount you, the provider, charged. Your coinsurance, if applicable will be determined from the allowed amount.

8. Coinsurance Amount: Amount represents amounts responsible from the patient through coinsurance.


10. Deductible Amount: This amount reflects the deductible requirement at the time charges were processed. If you see an amount in the deductible column, the patient is responsible for these amounts.

11. Not Covered: Any specific amount that was determined to be ineligible for payment by the plan.


13. OIC Paid: Amount represents the amount covered by another health plan or insurance company on behalf of the patient.

14. Net: Sum the health plan will be reimbursing the provider.

15. Net + W/H: Sum the health plan will be reimbursing the provider added to the withhold amount.

16. Vendor Totals: This section provides totals for each column for your entire document.

17. Explanation Code/Description Tab: This code is used to explain the reason something is not covered or is discounted from the billed amount or deductible, coinsurance, and copay explanations.

18. Appeal Rights: This will be the procedure and information needed to file a formal review for any denied claim.
## SIHO Insurance Services Authorization Form

**Phone:** 800-553-6027  
**Please complete and fax to:** 812-378-7054 or 317-860-3601

| **PATIENT NAME:** | **DOB:** / /  
| **Patient ID #** | **Diagnosis (ICD-10 Code):**  
| **Date of Service:** / /  

### REQUESTING PHYSICIAN NAME:

| **Contact Name:** |  
| **Address:** |  
| **Office Phone:** | **Contact Phone:** | **Office Fax:**  
| **Provider NPI:** | **Tax ID:** | **Vendor NPI:**

### VENDOR / FACILITY NAME / REFERRED-TO PHYSICIAN

| **Vendor NPI:** | **Tax ID:**  
| **Name of Vendor/Facility/Physician:** |  
| **Address:** |  
| **Phone:** | **Fax:**

### DME

| **Contact Name:** | **Phone:**  
| **Rentals $** | **Duration of use:**  
| **Purchase $** | **Type of equipment/HCPs:**  

*Please attach as applicable: MD order, 02 sats, Compliance, Sleep Study, Improvement statement*

### MEDICATIONS

- **Drug name:**
- **Other drugs tried and failed:**
- **Physician will be supplying and billing for medication**  
  (Note: Otherwise, group pharmaceutical will be contacted for shipment of drug)  
  *Most attach MD order and clinical information*

### OUTPATIENT SERVICES

- **PT / OT / ST (attach eval/Tx plan and script)**
- **Sleep Study**
- **MRI / CT / PET / Cardiac Scan**
- **Acupuncture**
- **Colonoscopy / EGD**
- **Outpatient Surgery**

### Inpatient Surgery Procedure Codes:

- **Other:**
- **Referral**
- **Retro**

Please include any clinical information and physician orders to justify this request.

---

Review Date: 11/23/2016. Revised Date: 08/25/2016
# SIHO Preventative Benefits

## SIHO Insurance Services Comprehensive Preventive Health Benefit

These benefits are fully compliant with the Affordable Care Act (PPACA).

### Wellness Exam:
- **Men** - One per year
- **Women** - One per year with family physician, one per year with OB/GYN, if needed

## Childhood Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>0-6 Months</th>
<th>1-2 Years</th>
<th>3-4 Years</th>
<th>5-6 Years</th>
<th>7-11 Years</th>
<th>12+ Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis</td>
<td>DTap</td>
<td>DTap</td>
<td>DTap</td>
<td>DTap</td>
<td>DTap</td>
<td>VTaP</td>
</tr>
<tr>
<td>Human Papillomavirus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HPV 2 Doses</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>BCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Inf (year)</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>PCV</td>
<td>PCV</td>
<td>PCV</td>
<td>PCV</td>
<td>PCV</td>
<td>PCV</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Hep A</td>
<td>Hep A</td>
<td>Hep A</td>
<td>Hep A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Hep B</td>
<td>Hep B</td>
<td>Hep B</td>
<td>Hep B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated Poliovirus</td>
<td>IPV</td>
<td>IPV</td>
<td>IPV</td>
<td>IPV</td>
<td></td>
<td>IPV</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MV</td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Varicella</td>
</tr>
<tr>
<td>Rabies</td>
<td>Rabies</td>
<td>Rabies</td>
<td>Rabies</td>
<td>Rabies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemophilus Influenza Type B</td>
<td>HBB</td>
<td>HBB</td>
<td>HBB</td>
<td>HBB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Preferred age for vaccine is indicated where specific vaccine is listed in colored box.

*Varicella expanded for 2nd dose to age 18.

## Services for Children

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Age Group</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face and eye washes, percutaneous test*, hearing test</td>
<td>Newborn</td>
<td>Developmental/Behavioral Assessment/Autism</td>
</tr>
<tr>
<td>Fluoride supplement</td>
<td>Children without fluoride in water source</td>
<td>All Ages</td>
</tr>
<tr>
<td>Iron Screening and supplementation</td>
<td>All Ages</td>
<td>Lead Screening</td>
</tr>
<tr>
<td>HIV Screening</td>
<td>Age 12 and above</td>
<td>Dystrophism Screening</td>
</tr>
<tr>
<td>Visual Acuity</td>
<td>Up to Age 6</td>
<td>Height, Weight and Body Mass Index measurements</td>
</tr>
<tr>
<td>Oral Dental Screening</td>
<td>During P/BE visit</td>
<td>Medical History</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>All Ages</td>
<td>All Children throughout development</td>
</tr>
</tbody>
</table>

## Services for Pregnant Women

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>For Those At Risk</td>
</tr>
<tr>
<td>HIV</td>
<td>Screening</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Lab test</td>
</tr>
<tr>
<td>Iron Deficiency Anemia</td>
<td>Lab test</td>
</tr>
<tr>
<td>Gestational Diabetes Screening (between 24 &amp; 28 weeks)</td>
<td>Lab test</td>
</tr>
<tr>
<td>Rh Incompatibility</td>
<td>Lab test</td>
</tr>
<tr>
<td>Syndactyly Screening</td>
<td>Lab test</td>
</tr>
<tr>
<td>Breast Feeding Interventions*</td>
<td>Counseling, Support &amp; Supplies</td>
</tr>
<tr>
<td>Niacin*</td>
<td>Counseling</td>
</tr>
<tr>
<td>Folate &amp; Folicul*</td>
<td>Women capable of becoming pregnant</td>
</tr>
</tbody>
</table>

## Services for All Women

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Violence Counseling &amp; Screening</td>
<td>Annual</td>
</tr>
<tr>
<td>Contraceptive Methods*</td>
<td>Covered unless religious exemption applies</td>
</tr>
</tbody>
</table>
The SIHO Preventive Health Benefit Guidelines are developed and periodically reviewed by SIHO's Quality Management Committee, a group of local physicians and health care providers. The QMC reviews routine care services from the American Academy of Family Practice Standards, American College of Obstetrics and Gynecology Standards, Center for Disease Control Recommendations, American Cancer Society Recommendations, American Academy of Pediatric Standards and U.S. Preventive Services Task Force Recommendations.

These recommendations were combined with input from local physicians and the standard Preventive Health Benefit was developed. These standards and recommendations are reviewed every one to two years, and the benefits are updated as needed.

Please note that your physician may recommend additional tests or screenings not included in this benefit. If you receive routine screenings that are not listed in this brochure you may have financial responsibility for those charges.

A screening procedure performed when there is a family history or personal history of a condition (and which does not fall within the listed age/ frequency criteria of the Preventive Health Benefit) will be covered under the major medical benefit.

*Please contact SIHO Member Services at 800.443.2680 for specific coverage information.
PROVIDER DATA SHEET

GENERAL INFORMATION FOR CORPORATION

<table>
<thead>
<tr>
<th>Name of Corporation as shown on legal tax I.D.</th>
<th># of Providers in Group</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Office Address</th>
<th>City</th>
<th>ST</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal Tax I.D. (please attach a W-9)</th>
<th>Group NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Billing Address (if different from primary office address)</th>
<th>City</th>
<th>ST</th>
<th>Zip Code</th>
<th>Billing Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Office Contact</th>
<th>Title</th>
<th>*Secure Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office Phone</th>
<th>* Secure Office Fax</th>
<th>Clearinghouse</th>
<th>Submitter ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROFESSIONAL PROVIDER INFORMATION

(This information may be included in a spreadsheet format for multiple providers.)

<table>
<thead>
<tr>
<th>Provider Last Name</th>
<th>Provider First Name</th>
<th>Initial</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Specialty (as you wish it listed in the directory)</th>
<th>Sub-Specialty</th>
<th>CAQH#</th>
<th>UPIN #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Provider NPI</th>
<th>Board Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>License # – Indiana</th>
<th>License # - Kentucky</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Taxonomy Code

HOSPITAL AFFILIATIONS

<table>
<thead>
<tr>
<th>Hospital</th>
<th>City, State</th>
<th>Type of Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital</th>
<th>City, State</th>
<th>Type of Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Applicant ___________________________ Date of Application ________________

Printed Name of Applicant ___________________________

Internal Use Only: ___________________________ Signature, Date and File Code

Page 35