

“One Call... One Solution”

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Provider manual

5/2007

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Introduction

Mission Statement:

Progressive Homecare is a high quality health care services organization comprised of a cohesive team of dedicated medical professionals, operating in a challenging and rewarding environment, whose goal is to implement innovative and cost effective health care services.

Progressive Care Network company overview:

Progressive Care Network is a provider network specifically designed to service managed care contracts. The Network has been extremely successful in meeting the specific needs of its referring insurance case managers, discharge planners, and physicians. We are unique in that all of the providers are trained to provide services according to a managed care model. Our clients have services ranging from skilled nursing and therapy to nationwide DME and infusion needs. The need for home health services continues to grow and we will make every attempt to keep inpatient hospital stays to a minimum by working to prevent recurrent hospitalizations. Our services include but are not limited to the coordination of skilled services, hospice services, medical equipment, and infusion needs for patients in the home.

As a group of dedicated and talented professionals, we work in our community to deliver infusion and home care services of the highest quality. We work as a team with a shared commitment to deliver patient centered care. Our services are delivered with excellent problem solving, and clinical skills. As a member of the local health care community, we seek collaborative partnerships with physicians, facilities, case managers, vendors, and other home care agencies. Effective, timely, and honest communication are the hallmark of our company. With respect for the value of human and material resources, we seek to deliver our services in the most cost effective, professional manner possible. Progressive Care Network is a provider network specifically designed to service managed care contracts. The network has been extremely successful in meeting the specific needs of its referring insurance case managers, discharge planners, and physicians.

As a provider network of...

- Skilled Home Care
- Durable Medical Equipment
- Physical / Occupational / Speech Therapy
- Infusion Services
- Supply Services

PCN provides home care solutions throughout Indiana.

Progressive Care's Provider Network provides a wide variety of home care services. These services include, but are not limited to, the following

Home Health Services

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Work
- Home Health Aid
- Hospice Services
- Ambulatory Infusion Suite

Home Medical Equipment

- Oxygen
- Respiratory Equipment
- CPAP/BIPAP
- Hospital Beds
- Wheelchairs
- Walkers/Canes
- CPM
- Power Wheel Chairs
- Scooters

Specialty Medical Supplies

- Ostomy Supplies
- TENS Units
- Wound Care Supplies
- Medical/Diabetic Supplies
- Insulin Pumps & Related Supplies

High Risk OB

- Home Uterine monitoring
- Non-Stress test
- Pump Therapy
 - ✓ Terbutaline
 - ✓ Zofran
 - ✓ Reglan

Home Infusion Therapy

- Antibiotic
- Hydration
- Total Parenteral Nutrition (TPN)
- Inotropic
- Clotting Factor
- Enteral
- Injection Therapy
- Growth Hormone
- Immunoglobulin Therapy (IVIG)
- Neupogen
- Pain Management
- Chemotherapy

Administrative procedures

Claim submission:

Claims should be submitted to,

Progressive Care Network
Attention Claims department
By fax,
(317) 596-3711

All claims should be submitted on a CMS 1500 or a UB04

Electronic claim submission:

We Do Not at this time accept electronic claims, to submit a claim please refer to the above instructions.

Resubmitting claims:

We ask that you Do Not resubmit claims, due to the potential for duplication of claims and subsequent denial of the claim. If you wish to inquire about the status of a claim, please complete the attached claim status inquiry form and fax to (317) 596-3390.

Benefit coordination:

Benefit coordination is a provision of insurance plans that prevents double recovery of claims. It also designates the order in which multiple carriers pay benefits.

Insurance plans we participate in,

- Advantage Health Solutions
- Advantra Freedom
- Beech Street PPO
- Benefit Management Svcs
- Cardinal PPO
- Clarian Medicare Advantage
- Core Source
- Focus Managed Care
- Howard Regional Network
- Humana PPO & Medicare
- IHN – Great West
- Interplan
- MDWise Methodist
- MDWise St. Francis
- Medical Mutual of Ohio
- NGS American
- Premier Healthway
- Prime Health Services
- PHCS
- PPOM
- Senior Smart Choice
- SIHO
- St. Francis Health Network
- Sisters of St Francis
- Three Rivers

Contracting:

Initial credentialing:

PCN contract packets are available through the network director. All contracted providers are required to present and maintain all professional credentials. These credentials will be verified and kept on file by the provider services department. A signed contract and application form as well as liability insurance will also be required. The review and approval process will be completed within 60 days of receiving the completed contract.

Each provider must be fully credentialed prior to providing goods or services to the patient. Providers rendering services prior to credentialing may not be reimbursed for the service provided; Emergent care should never be withheld pending contract approval.

Re-credentialing:

Providers will be required to complete a re-credentialing application every three years, as well as provide a current state license, liability insurance, JCAHO/AAAH/URAC or applicable accrediting body certification, If not accredited a copy of the last annual state survey.

Contract information:

The following information should be included with your application,

- The organization's state license to provide health services (if applicable).
- The organization's professional and comprehensive general liability insurance certificate.
- URAC/JCAHO/AAAH/URAC or applicable accrediting body certificate (if applicable).
- If not accredited a copy of the last annual state survey and corrective action plan (if applicable)
- Copy of W-9
- Listing of insurance contracts (Anthem, Aetna, etc...)
- NPI Number (national provider number)
- Tax ID number (TID)
- Medicare number (if applicable)
- Medicaid number (if applicable)
- Date of incorporation
- Corporate contracts
 - Documentation for all locations
- Individual branch contract
- A copy of the policy and/or procedures related to your QI or QA program

Patient privacy

PCN is adamant about protecting patient health information, with that in mind please review the following information regarding HIPPA (Health Insurance Portability and Accountability Act of 1996).

- “Record” means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for Progressive Care Network.
- “Protected Health Information” shall mean Individually Identifiable Health Information.
- Provider shall ensure that its directors, officers, employees, contractors, and agents do not disclose Protected Health Information received from Progressive Care Network in any manner that would constitute a violation of the Privacy Standards.
- Provider will implement all appropriate safeguards to prevent the use or disclosure of Protected Health Information.

All providers prior to rendering any goods or services shall be required to review and sign a HIPPA addendum.

Report Contact

All vendors providing skilled services, such as Nursing, Physical, Occupational, and Speech therapies, will establish one contact person at your location that will be responsible for gathering and communicating all pertinent information to PCN’s Nurse Liaison weekly and as the need arises.

- Weekly: Update on all PCN patients that are actively being seen. We will require information such as number of visits made to each patient in that week, confirmation of weekly report having been called to the case manager, Etc.
- Within 24 hours: Missed visits (regardless of who initiated the missed visit patient or service provider). Hospital admissions, Discharge from your service, Patient, Family or Physician complaints, Emergent concerns.

Referral guidelines

Commercial plans: Medicare programs: Medicaid programs

- Pre-certification is required for all services.
- Retroactive referrals may be processed but payment is not guaranteed. Claims may be subject to filing penalties.
- **Filing limits are 55 days from the date of service.**
- Members must meet guidelines for the Medicare and Medicaid programs to receive services under our Medicare and Medicaid programs.

Please note that the following items require pre-certification. This list is not exhaustive and other items and / or services may also require pre-certification.

- Durable medical equipment
- Rental of durable medical equipment
- Home health care
- Hospice care
- Physical, speech, and occupational therapy
- Medical supply orders
- IV medications
- Oxygen and oxygen supplies

Be advised: if pre-certification is not obtained, the claim may be denied, or the patient may be subject to a reduction in benefits.

Referrals:

Referral process PCN driven:

- PCN will contact vendor referral intake department via telephone.
- Referral information will be sent via fax to the vendor i.e. demographics, orders, treatment or services ordered.
- Vendor to supply PCN appropriate HCPC codes for DME and / or supplies.
- Services will be scheduled and the patient notified by vendor within two (2) hours of the referral being accepted.
- Authorization for services will be given by Progressive Care Network.
- Notification of report entity will be given at the time of referral. The report MUST be called post admit and weekly on skilled cases.
- For authorization extensions on DME supporting documentation must be submitted.

Referral process vendor driven:

- Fax referral to (317) 596-2809
- Please complete all applicable information on the PCN referral form (see attached referral form).
- Include with the referral form all supporting documentation, such as those listed below if applicable.
 - a) Written script.
 - b) Confirmation of a verbal script.
 - c) Certificate of medical necessity (CMN).
 - d) Letter of medical necessity (LMN).
 - e) History and Physical
 - f) Recent lab / x-ray results.
 - g) Therapy notes.
 - h) Height, weight & a list of allergies.
 - i) Recent hospital progress notes.
 - j) Treatments that have been tried and failed.
 - k) Complete demographic information.
- Ensure you have documented and included the proper HCPC codes.
- Ensure that you have included the proper service dates.
- As well as the appropriate amount of units have been requested.
- In non-emergencies, please ensure all information is included with the referral PRIOR to faxing it for authorization.

Allow 7-10 days for review and processing prior to checking on the referral's status.

* Please note: A referral authorization does not guarantee payment. Reimbursement for services is subject to member eligibility and benefit coverage at the time that services is rendered.

Referral Fax: (317) 596-2809

Authorizations:

Physical, Occupational, Speech Therapies:

When a physician (either the primary care or a specialist that has been approved to consult and treat the patient) orders therapy, please include the following:

- Signed script or a confirmation of a verbal order.
- Demographic information
- Number of visits being requested.
- Supporting documentation, such as (swallow study, PT /OT notes, etc)
- Diagnosis specific to therapy being ordered. Please include ICD-9 codes
- If the patient requires additional visits, the vendor must provide PCN with additional supporting documentation.

Once this information is received PCN will submit it to the medical review department for approval.

Therapy providers are required to notify PCN when services are rendered to PCN patients.

Failure to notify PCN prior to rendering services may result in denial of the claim, Emergent care should never be withheld pending authorization.

Nursing / Infusion services:

When a physician (either the primary care or a specialist that has been approved to consult and treat the patient) orders Nursing / Infusion services, please include the following:

- Signed script or a confirmation of a verbal order.
- Demographic information
- Height, weight and list of allergies.
- Number of visits being requested.
- Return PCN fax cover letter with Nurses name and contact telephone number.
- List of current medications the patient is taking.
- Documentation to support treatment orders.
- Diagnosis specific to treatment being ordered. Please include ICD-9 codes
- If the patient requires additional visits, the vendor must provide PCN with additional supporting documentation.

Once this information is received PCN will submit it to the medical review department for approval.

Therapy providers are required to notify PCN when services are rendered to PCN patients.

Failure to notify PCN prior to rendering services may result in denial of the claim, Emergent care should never be withheld pending authorization.

Durable medical equipment:

When a physician (either the primary care or a specialist that has been approved to consult and treat the patient) orders equipment, please include the following:

- Signed script or a confirmation of a verbal order.
- Demographic information
- Number of units being requested.
- Height and weight.
- Documentation to support equipment orders.
- Diagnosis specific to equipment ordered. Please include ICD-9 codes
- HCPC codes specific to ALL items ordered.
- If the patient requires additional units, the vendor must provide PCN with additional supporting documentation.

Once this information is received, PCN will submit it to the medical review department for approval.

DME providers are required to notify PCN when equipment is rendered to PCN patients.

Failure to notify PCN prior to delivery of equipment may result in denial of the authorization.

The following guidelines apply to the purchase and rental of durable medical equipment (DME),

- Authorization is required for the purchase and / or rental of all durable medical equipment.
- **Authorization requests for items in the Medicare/Medicaid programs must meet the specific Medicare/Medicaid guidelines.**
- **Provider of service must maintain a chart that meets Medicare/Medicaid requirements.**

Medical supplies:

The medical supply authorization process is the same as the DME authorization process. HCPC codes must be specific to each item supplied.

Recurring Items:

Please keep in mind that many items such as, CPAP supplies, Nebulizer supplies, Etc... are approved for 36 months for MPlan and Senior Smart Choice (SSC) and 12 months for St Francis Health Network (SFHN).

Billing:

Identification:

The member insurance ID card does not guarantee payment.

Covered benefits:

All services require pre-certification. If there is any question as to what goods and or services are covered, please contact PCN directly at (317) 596-2805 to verify coverage.

Medical coordination:

The purpose of medical coordination is to help ensure that patients receive the maximum insurance benefit possible, along with all clinically necessary and appropriate care, as ordered by their physician.

Commercial:

- Claims should be billed just as you would any commercial insurance company.
- Commercial insurances are much more lenient in regard to what will be authorized. Pre-certification is required for all services.
- Retroactive referrals may be processed but payment is not guaranteed. claims may be subject to filing penalties
- Filing limit is 55 days from the date of service.
- DO NOT bill for any items that are not on the authorization provided by Progressive Care Network.

Medicare programs:

- Claims should be billed just as you would to Medicare.
- Medicare guidelines must be followed.
- All items require authorization.
- Retroactive referrals may be processed but payment is not guaranteed. Claims may be subject to filing penalties.
- Filing limit is 55 days from the date of service.
- DO NOT bill for any items that are not on the authorization provided by Progressive Care Network.

Medicaid programs:

- Claims should be billed just as you would to Medicaid.
- Medicaid guidelines must be followed.
- All items require authorization.
- Retroactive referrals may be processed but payment is not guaranteed. Claims may be subject to filing penalties.
- Filing limit is 55 days from the date of service.
- DO NOT bill for any items that are not on the authorization provided by Progressive Care Network.

Billing tips

- Copy the claim before faxing and fax the copy to (317) 596- 3711.
- Please include a fax cover letter and include on it,
 1. Patients name.
 2. Date of service.
 3. A return fax number.
 4. The name of a contact person at your location.

The cover letter will be faxed back to you within 1-2 business days as a confirmation of receipt, please retain this for your records.

- Ensure the shading is not set to dark.
- Do Not set your fax on high resolution.
- Use black ink.
- Print legibly.
- Mail claims that have a primary EOB attached.
- Remember to put your KH, KI, and KJ modifiers on any Medicare program rental claim.
- Medicare has changed their capped rental policy. Effective as of 12-31-05. Any capped rental items delivered after 13 rental months, MS charges will not be billable on these items.
- Oxygen fills are paid on a per month basis, so bill 1 unit for each month for commercial rental equipment. Medicare program fills are only billable for purchased equipment.
- Rental items provided to Medicare program recipients are based on Medicare guidelines. If wheelchair accessories are approved as rentals (i.e. E0971, E0973,E0961,etc) and are considered capped rentals by Medicare, they will be considered purchased after 13 rental months.
- Remember to bill according to the authorization. Items not authorized will be rejected.
- Medicaid program claims need to be billed according to Medicaid requirements.
- Skilled services are to be billed based on units. RN visits are to be billed per hour. PT /OT and ST are billed at 15 minute increments.
- Remember to bill the overheads on a separate line.
- Begin using NPI numbers on all claims beginning 4/15/07. This includes the ordering physicians NPI number and not the UPIN number.

Billing Patients :

Providers Are Not to bill patients directly, except for required co-insurance or deductibles as determined by the patient's insurance plan. Co-Insurance and or deductibles are billable after payment is received from PCN. Co-Payments may be collected at the time of service for identified Co-payment amounts. Example \$20.00 Co-Payment for Nursing or Therapy Visit.

Denied claims:

Denied claims are faxed or mailed back to the vendor with an explanation of the denial reason. Corrected claims must be re-submitted; they should be clearly marked as,

- Corrected claim.
- And the correction clearly circled.

Collections:

If you have any questions regarding claim status, you may inquire after 60 days by contacting our claims department at (317) 596-2805 or fax inquiry to (317) 596-3711.

Complaints and Appeals

Progressive Care Network quality management program endeavors to ensure quality healthcare for our patients. Through continuous monitoring we are constantly striving to improve the healthcare our patients receive.

Denied claims :

Denied claims will be either faxed or mailed back to the vendor with a denial reason. A phone call may also be made to the vendor. Corrected claims must be re-submitted. These should be clearly marked as CORRECTED CLAIM and the correction circled.

Complaints:

PCN recognizes that on occasion situations may arise that do not meet the expectations of our providers. When this happens PCN encourages providers to contact us immediately.

Appeals:

If a provider feels that a mistake has been made in the processing of a claim a written appeal may be submitted to the appeals coordinator at,

Progressive Care Network
Attention Appeals coordinator
8930 Bash St, Suite G
Indianapolis, Indiana 46256

Or by fax at (317)596-3390

Top Ten most often denied items:

- | | |
|------------------------------------|--------------------------------|
| 10) Bone growth stimulator | 5) Semi-electric hospital beds |
| 9) Insulin pump | 4) Oxygen |
| 8) CPM (continuous passive motion) | 3) Wheelchair |
| 7) Skilled Nursing/Therapy visits | 2) CPAP machine |
| 6) Walker-vs.-Wheelchair | 1) Tens Unit |

To often requests for authorization are denied due to lack of supporting documentation. Listed below are the top ten along with the most often requested accompanying records.

1) TENS units:

- Supporting diagnosis .
- History of tried and failed alternative treatments.
- Physical therapy notes.
- Script from the physician.
- Letter of medical necessity outlining need by the Physician. (not a form)

2) CPAP machine:

- Supporting diagnosis .
- Script from the physician.
- Copy of the sleep study.

3) Wheelchair:

- Script from the physician.
- Evaluation from a physician and/or physical therapist.
- Distance the patient can independently ambulate.

4) Oxygen:

- Supporting diagnosis .
- Script from the physician.
- Copy of the oxygen saturation levels on room air.

5) Semi-electric hospital beds :

- Supporting diagnosis .
- Script from the physician.

6) Walker-vs.-Wheelchair:

- Very often senior Smart Choice will not cover both.

7) Skilled Nursing/Therapy visits

- No report called to the Case-manager.

8) CPM (continuous passive motion)

- Supporting diagnosis .
- Script from the physician.
- Copy of the physical therapy notes.

9) Insulin pump

- A1C.
- Blood sugar log.
- Script.
- Letter of medical necessity outlining need by the Physician. (not a form)

10) Bone growth stimulator

- Proof of failure , of other treatments, must meet Medicare criteria for type; (i.e., long bone – vs. – spinal).
- Letter of medical necessity outlining need by the Physician. (not a form)
- Script.

Patient Satisfaction

PCN takes patient satisfaction very seriously, and promptly responds to any patient complaints or concerns. When services do not meet patient expectations he or she may initiate a complaint or appeal, by contacting us directly.

Periodically PCN will send out patient satisfaction surveys, in an effort to ensure quality of care.

Helpful web links

Medicare website

<http://www.administar.com/>

Medicaid website

<http://www.indianamedicaid.com/ihcp/index.asp>

Centers for Medicaid & Medicare services web site

<http://www.cms.hhs.gov/>

Progressive Care Network

<http://www.progressivecarenetwork.com>

Glossary

Allowable expenses:

These are necessary, reasonable and customary items of expense.

Benefit less benefit COB :

PCN processes the claim using the patients benefit and then subtracts their primary benefit.

COB:

PCN will process the balance of the claim after the primary benefit has been paid. Charges paid will not exceed what PCN would have paid.

EOP: Explanation of payment.

Medicare programs:

Medicare is a federal health insurance program for people 65 years or older and those with certain disabilities. It is composed of two parts, Part A (Hospital inpatient) and Part B (Hospital outpatient).

Medicaid programs:

Medicaid provides matching funds to states that help provide medical care for low income people. Once Medicaid has been billed the provider must accept reimbursement as payment in full, and Can Not bill the patient for the remaining balance.

Primary:

Patient's first source of insurance coverage, as determined by a coordination of benefits specialist

Secondary:

Patient's secondary source of insurance coverage, as determined by a coordination of benefits specialist

Unit:

Units are based on HCPC code definition, and should be charged accordingly. For example;

(E1390R oxygen concentrator 1 unit = 1 month of rental)

(J3370 Vancomycin 500mg = 1 unit)

(A6024 Collagen dressing per 6 inches = 1 unit)

PROGRESSIVE CARE NETWORK INSURANCE VERIFICATION

Requesting Vendor: _____ Phone #: _____

Contact Person: _____ Fax #: _____

Request Date: _____

Patient Name: _____ SSN: _____ Birth date: _____

Insurance Type: **Commercial** **Medicare Program** **Medicaid Program**

Policy Holder: _____ SSN: _____

Birth date: _____ Patient Relationship to Insured: _____

Policy Number: _____ Group Number: _____

Employer: _____

Effective Date of Policy: _____ Medicare Supplement: Y N

Coverage Amount: % Major Medical Coverage: Y N

Deductible: _____ Has Deductible Been Met: Y N

Out Of Pocket Max: _____ After _____ Amt: _____ Total: _____

Lifetime Max: _____ Pre-existing Condition Clause: Y N

Coverage Under Drug Plan: Y N Policy Covers Skilled Nursing: Y N

Pre-Certification Is Required:

Phone Number: **317-596-2805**

Case Manager Name and Phone Number: To be provided by PCN as needed

Mailing Address for Claims:

Progressive Care Network

8930 Bash St. #G

Indianapolis, IN 46256

Fax Number for Claims:

317-596-3711

Please fax claims with a cover letter listing Patient Name/s and Date/s of Service.

Please include a return number to fax claim receipt confirmation to.

If claims are faxed, please do not mail them.

Progressive Care Network Authorization Request Form

Phone: 317-596-2805 Fax: 317-596-2809

Return to: _____ **Company:** _____ **Date:** _____

Phone: _____ **Fax:** _____

Patient Name: _____ **D.O.B.** _____

Social Security Number: _____

Primary Insurance: _____ **Member Number** _____

Secondary Insurance: _____ **Member Number:** _____

Ordering MD: _____ **Phone Number:** _____

ICD9: _____ / _____ / _____ / _____ / _____ / _____

HCPC Code	Item Description	Unit	Start Date	End Date	Comments

IN ORDER TO OBTAIN AUTHORIZAITON THE FOLLOWING DOCUMENTS ARE NECESSARY. **DEMOGRAPHICS, ORDERS, CMN, Qualifying Documentation to meet program requirements i.e. Medicare, SSC, MDWise**
FEEL FREE TO SEND ANY ADDITIONAL DOCUMENTATION AS WELL.

ANY FORMS THAT ARE NOT COMPLETE ARE SUBJECT TO BE RETURNED.

Progressive Care Network Claim Status Inquiry

Vendor Name:

Contact Person:

Phone #:

Fax #:

Patient Name	ID #	Date of Service	HCPCS	Billed Amount
1				

PCN Response:

2				
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PCN Response:

3				
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PCN Response:

4				
----------	--	--	--	--

PCN Response:

5				
----------	--	--	--	--

PCN Response:

6				
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PCN Response:

**Fax request to
Progressive Care Network
317-596-3390**

Progressive Care Network

8930 Bash St, Suite G
Indianapolis, Indiana, 46256
Phone (317) 596-2805

Fax (317) 596-2809 (referrals)
Fax (317) 596-3711 (claims)
Fax (317) 596-3390

Sandra Arbuckle- President / CEO

Nancy Ream- Senior referral intake specialist
nream@progressivecarenetwork.com

Lori Norberg- Billing specialist
lnorberg@progressivecarenetwork.com

www.progressivecarenetwork.com