STREAMLINEPT

PROVIDER MANUAL






Dear Valued Provider,

We are pleased to welcome your facility and providers to Streamline's Premier Network of Physical and Occupational Therapy Centers. This manual is designed to complement your Streamline contract, offering essential information to support our continued collaboration. Below, you will find an introduction to Streamline—our mission, services, and partnership approach with contracted providers.

Streamline has established a premier network of high-quality therapy services. Our clients include many of the nation's leading workers' compensation insurers, third-party administrators, and self-insured employers. If you need to verify whether a specific company is a Streamline client, please contact us at providerrelations@streamlineworkcomp.com.

Since our founding in 2013, Streamline has experienced consistent and substantial growth. Our mission is to connect patients with the most qualified therapists, ensuring the right services produce optimal outcomes. We achieve this through our partnership with a premier network of therapy centers. Our clients benefit from high-quality therapy services, expedited treatment and evaluation, and prompt reporting turnaround times. As a provider, you gain increased patient volume without marketing expenses, pre-authorized referrals facilitated by Streamline, and timely financial payments as per our agreement.

Key to our success is Streamline's unwavering commitment to quality care and customer satisfaction. We carefully select facilities that meet our clients' needs, ensuring comprehensive geographic coverage, exceptional care standards, and efficient scheduling. In return, we help maximize your patient volume while guaranteeing prompt and reliable payments.

At Streamline, we are dedicated to fostering strong relationships within the healthcare community and take pride in our carefully curated network of providers—choosing only leaders in the field of therapy. We look forward to a successful and enduring partnership. Thank you for your participation.

Sincerely,

Danita Durso

Danita Durso

Provider Relations Manager – PT

CONTENTS

STREAMLINE PHILOSOPHY

Exceptional Service is Our Standard

Our U.S.-based customer service professionals are highly trained, knowledgeable, and empowered to deliver an unparalleled experience to our clients, providers and patients. Understanding that no two injuries are alike, they focus on the critical details that drive optimal outcomes.

Flexible and Tailored Solutions

At Streamline, our sole focus is Workers' Compensation. We recognize the complexities involved in these claims and are dedicated to simplifying the process for our clients and providers. Founded by industry experts in workers' compensation and healthcare, we have developed a business model that fosters success for payors, providers, and patients alike.

Quality Providers, Proven Results

Timely patient care is essential. Upon receiving a referral, our customer service team promptly contacts the injured worker to coordinate scheduling with one of our high-quality, strategically located providers. Our commitment to efficiency ensures that patients receive the right care at the right time, facilitating better recovery outcomes.

COMMITMENT TO PATIENT RIGHTS AND PROVIDER SATISFACTION

Streamline upholds the rights and responsibilities of all patients, ensuring their dignity, privacy, and overall well-being. We are dedicated to delivering high-quality therapy services that prioritize patient satisfaction and reflect the highest standards of care. We encourage you to share this statement with patients during their initial appointment.

Streamline Patient Rights Statement

Patients have the right to receive quality therapy services from top-tier providers in a safe, comfortable, and supportive environment. Streamline is committed to upholding the following patient rights:

- Patients have the right to receive therapy services free from financial incentives that encourage over- or under-utilization.
- Patients have the right to therapy services from providers whose care is regularly evaluated for quality and appropriateness.
- Patients have the right to have their concerns or complaints regarding their therapy addressed promptly and professionally.
- Patients have the right to receive high-quality therapy.
- Patients have the right to the confidentiality of their health information and the protection of their privacy.
- In certain states, workers' compensation patients have the right to choose their provider.

Provider Responsibilities

To ensure compliance with these standards, providers are expected to:

- Review the Streamline Patient Rights Statement.
- Offer patients the opportunity to discuss their rights and responsibilities.
- Educate patients on essential topics, including:
    - Procedures to follow in case of a clinical emergency.
    - Confidentiality policies and their scope.
    - The patient complaint resolution process.
    - Treatment expectations and Streamline's responsibilities.
- Distribute the Streamline Patient Rights Statement as needed.
- Provide clear instructions on when and how to share the statement with patients.

COMMITMENT TO PROVIDER SATISFACTION

Provider satisfaction is a key performance measure at Streamline. We value provider feedback as a fundamental part of our quality assurance program. Periodically, we conduct surveys to assess provider satisfaction with our services and identify areas for improvement.

Provider Responsibilities

To support this initiative, providers are asked to:

- Complete satisfaction surveys within the specified timeframe.
- Provide feedback, suggestions, and inquiries to Streamline as needed.

Streamline's Responsibilities

- Monitor provider satisfaction with Streamline's policies, procedures, and services.
- Share aggregate results of provider satisfaction surveys with clients and stakeholders.
- Utilize survey findings to identify areas for improvement and implement necessary changes to enhance policies, procedures, and services.

At Streamline, we are committed to fostering strong relationships with both patients and providers, ensuring the highest standards of care and service delivery.

PROVIDER INFORMATION UPDATES AND COMPLIANCE

To ensure seamless service for our clients and prompt reimbursement for providers, Streamline requests that providers notify us of any operational or administrative changes, including:

- Opening or closing of a facility/office.
- Updates to phone, fax, or email contact information.
- Change in ownership.
- Tax ID changes (must be submitted in writing with an updated W9 form).
- Changes in lead therapist.
- Modifications to service address.
- Updates or additions to remittance address or billing service.
- Changes in hours of operation.
- Changes or updates in services such as massage, acupuncture, chiropractic, etc.
- Updates affecting credentialing status (licensure, medical sanctions, etc.).
- Addition or discontinuation of a modality.
- Changes in accreditation status.

Please send all updates via email to providerrelations@streamlineworkcomp.com or fax the information to 904-944-4171.

Quality Assurance and Compliance

Occasionally, concerns regarding a facility or provider are brought to Streamline's attention. These typically fall into one of three categories:

- Service quality issues
- Medical report deficiencies
- Contract compliance matters

When potential service quality issues arise, a Streamline Provider Relations Specialist will reach out to the Office Manager to address and resolve the concern.

EVALUATION/PROGRESS/VISIT NOTES EXPECTATIONS

- Initial Evaluations: Must be submitted to Streamline within 24-48 hours of completion, including a proposed treatment plan, anticipated duration of care, estimated return-to-work timeline, and expected outcomes.
- Progress Reports: Required every 12 visits (or every 6 visits if requested by the client). Reports must include at least two of the following three objective measurements:
    - Pain scale
    - Strength scale
    - Range of motion
    - Providers may use their own reporting formats.

ONGOING COMPLIANCE AND PROVIDER RELATIONS

A Provider Relations Specialist may periodically contact your facility to discuss matters such as the timely submission of documentation and claims billing issues. Repeated contractual non-compliance may result in a reassessment of your relationship status with Streamline.

Streamline is committed to maintaining high standards of service and compliance, ensuring the best possible care for our patients and a streamlined experience for our providers.

CREDENTIALING

As part of Streamline's credentialing process, all contracted therapy facilities must undergo credentialing. Each facility is required to complete the process with the following requirements:

- Complete application
- Signed attestation page contained within the application stating any malpractice history
- Current W9
- State Licensure for lead therapist
- NPI for both facility and therapist
- Professional Liability Insurance - coverage amounts of $1M/$3M or as required by the law within the state
- Commercial General Liability Insurance
- Complete roster of both therapists and locations if multiple
- Accreditation of applicable
- Delegated Credentialing is available to providers. Please contact our Provider Relations team at providerrelations@streamlineworkcomp.com who will send an agreement to you for your review. The Delegated Credentialing Agreement stipulates that the provider will perform all required Credentialing of their practitioners with the understanding that Streamline reserves the right to audit a random sample of practitioner files.

RECREDENTIALING

As part of Streamline's re-credentialing process, all contracted facilities must undergo re-credentialing every three (3) years, or every two (2) years in Florida, in accordance with NCQA guidelines. Failure to comply with the re-credentialing requirements may impact the facility's relationship status with Streamline.

REFERRAL PROCESS

- Referral Submission: A Workers' Compensation adjuster, nurse case manager, or referring physician's office submits a referral to Streamline on behalf of the injured worker or patient.
- Facility Selection: Streamline identifies a suitable facility within a reasonable distance from the injured worker's home or workplace, ensuring the best available network provider.
- Appointment Scheduling: Streamline coordinates with the contracted facility to schedule the appointment for the injured worker.
- Appointment Confirmation: Once the appointment is scheduled, Streamline notifies the injured worker with the appointment details, including the location, contact information, date, and time. In addition, we send out a 1 day prior to appointment reminder to the injured worker. If rescheduling is required, Streamline facilitates a conference call between the injured worker and the facility to adjust the appointment as needed.
- Authorization Submission: Streamline sends the authorization, along with the referring physician's order, via fax or email to the provider.
- Billing & Reimbursement:
    - The provider submits the bill to Streamline within 30 days of the procedure using HCFA 1500 or UB-04, including ICD-10 and CPT codes with non-discounted pricing.
    - Streamline processes payment based on the contracted reimbursement amount and timeframe, adhering to applicable state laws.

SCHEDULING/COMPLIANCE

- Appointment Scheduling & Timeliness:
    - The provider agrees to schedule and see the patient within five (5) days of the initial scheduling call and, in all cases, before the patient's follow-up appointment with the referring or treating physician.
- Provider Selection Criteria:
    - Providers are chosen for referrals based on various factors, including:
        - Patient's location or geographic proximity (geo-coding)
        - Specific patient or referral requests
        - Appointment availability
        - Required treatment or service
        - Compliance with contractual obligations, including timely evaluations, documentation, and billing turnaround
- Mandatory Notification to Streamline's Operations Team

  Providers must immediately notify Streamline's Operations Team in the following situations:
    - **The prescribed treatment by the referring physician differs from the Streamline authorization form or the request made by the Streamline Case Coordinator.**
    - The patient fails to attend a scheduled appointment ("No Show").
    - The patient cancels an appointment and requires rescheduling.
    - The provider is unable to render the requested service, necessitating redirection to another provider or facility.
    - The provider needs to order additional visits.
    - A referring physician, nurse case manager, or attorney directly schedules the patient with the provider. In most cases, Streamline will follow up to confirm the referral. If no confirmation is received within 24-48 hours and the provider believes the case falls under Streamline's management, they must contact Streamline immediately.

AUTHORIZATION AND DOCUMENTATION PROCESS

Unlike traditional healthcare plans, the Workers' Compensation industry does not utilize member identification cards. Instead, Streamline issues an Appointment Authorization Form

- Once a patient's appointment is scheduled, Streamline sends the authorization form via fax or email to the provider.
- The form includes:
    - Patient details
    - Authorized services
    - Ordering physician information
    - Contracted Streamline payer details
    - A Healthcare Release Form that may be completed by the patient, if required by the provider, to authorize the release of medical records to Streamline.
- Important: The authorization form is not a prescription. If it is not received, please contact Streamline immediately.

Additionally, Streamline obtains the prescription from the referring physician and will fax it to the provider upon receipt.

CONSENT

- The provider/facility is responsible for ensuring the patient completes all required office forms, including:
    - A treatment consent form
    - An authorization form, if required, allowing the release of medical reports to Streamline
- Providers should review the notes section of the Streamline Authorization Form for any special requests.

EXCEPTIONS

If the provider determines that:

- The authorized therapy differs from the patient's prescription, or
- The requested therapy cannot be accommodated per the provider's established standards and protocols

The provider must:

1. Contact the referring physician immediately for clarification.
2. Document the outcome of the conversation in the report.
3. If the referring physician is unavailable, notify Streamline for assistance, follow the facility's standard protocols, and document all actions accordingly.

DIRECT SCHEDULE

At times, an insurance carrier or ordering physician may directly access a Streamline provider outside of the standard Streamline referral and scheduling process.

- In such cases, Streamline will notify the provider via phone to confirm our role as the payer.
- Following this notification, Streamline will fax the authorization for the patient.
- The provider should proceed with the scheduled service, submit medical reports, and bill Streamline following the standard process.

ADDITIONAL AUTHORIZATION/SCHEDULING GUIDELINES

Phone: (855) 877-9292 Fax: (904) 944-4176 Portal: www.streamlineworkcomp.com
Email (preferred): PhysicalTherapy@streamlineworkcomp.com

Scheduling:

- Streamline will reach out to the injured worker upon receipt of referral to obtain availability. We will schedule the Initial Evaluation appointment based on the injured worker's availability. Once scheduled, we will call and text the appointment details to the injured worker.
- Streamline will fax/email a copy of the authorization letter.
- Streamline sends an appointment reminder to the injured worker 24 hours before the Initial Evaluation.
- Contact Streamline immediately if the injured worker cancels or misses their Initial Evaluation appointment.

Authorizations:

- **To request additional authorization, you will need to submit a valid MD order to Streamline for approval.**

Valid MD Orders:	**Non-Valid MD Orders:**
MD order from physician	MD signed Initial Evaluation
MD signed Progress Note	Progress Note not signed by MD
Request for Authorization for CA	Work Status Report

- Once a decision is made, Streamline will call and send an authorization letter via fax or email to the provider. Additionally, a text message will be sent to the injured worker notifying them of the authorization and advising them to contact the provider for scheduling if an appointment has not already been set.
- Authorizations are issued based on the date of the physician's order or the timeframe specified by the adjuster. A specific number of visits are authorized for treatment. If any additional visits are needed, Streamline should be notified to coordinate additional authorization to prevent disruption in care.
- Streamline requests authorizations for ongoing therapy, newly affected body parts, and new service types as needed.

- Streamline does not authorize the dispensing of any Durable Medical Equipment (DME) or DME related supplies. All DME requests should only be made by the injured workers referring MD. **EXCEPTION**: Custom Splints.

- Streamline does not manage Transportation or Translation services. However, as a courtesy, Streamline will coordinate Transportation and Translation services for the Initial Evaluation only.

For any subsequent appointments, the injured worker is responsible for coordinating directly with the designated vendor to update scheduling as needed.

CASE MANAGEMENT AND VIST DOCUMENTATION

Streamline specializes in workers' compensation cases, where timely documentation is essential. Since many referred patients are out of work, prompt submission of notes and reports plays a critical role in determining their return-to-work status. Such Documentation shall be provided to Streamline as part of the standard course of care and at no additional charge to Streamline

Visit Management & Required Reports

Providers are required to submit the following reports at no additional charge to Streamline:

- Initial Evaluation
- Progress Notes
- Visit Notes
- Discharge Summary (if available)

Documentation & Follow-Up Process

- Initial Evaluation Follow-Up: Streamline will contact the provider two days after the scheduled Initial Evaluation to confirm the patient's attendance, obtain the Initial Evaluation report at no additional charge to Streamline, and gather details on upcoming appointments.
- Ongoing Patient Updates: An automated fax request for patient updates will be sent weekly.
- Inactive Cases: If 14 days or more have passed since the injured worker's last visit, Streamline will close the file. However, the case can be reopened if the injured worker schedules a future appointment.
- New Referral Creation: Streamline will close the existing referral and generate a new one if the injured worker:
    - Undergoes a new surgery
    - Transitions from therapy to a Work Conditioning/Hardening program
    - Transfers to a new provider
    - Experiences a 30-day gap in care

This structured approach ensures efficient case management while maintaining continuity of care for injured workers.

GUIDELINES FOR PHYSICAL THERAPY REPORTS

The following data should be included on each report submitted to Streamline.

- Provider Name
- Patient Information: This data should be labeled and included in the header of the report. (See Sample Header for preferred format below)
    - Patient Name
    - Patient DOB
    - Date of Service
    - Referring Information
    - Procedure Performed
- The Operations team will often request confirmation of dates of service after the last note they have on file. If this note does not read as a discharge, it is an accurate assumption by Streamline that there are visits or upcoming appointments beyond that date of service. If the request is to "confirm dates after a specific date", do not send that same date of service note. The OPS team is requesting to obtain any dates of service or upcoming appointments beyond that date. Please send details such as upcoming appointments, missed appointments or details explaining a gap in a patient's care so the OPS team is kept up to date on where the injured worker is in their treatment. If the injured worker has been discharged, the OPS team will need a discharge note indicating when the injured worker was discharged.
- If the provider is requesting additional authorization, the Operations team will need a progress note that is signed by the MD or a new order before authorization can be granted.
- The Operations team will call 2 business days after the initial evaluation is scheduled to confirm the IW attended the appointment and will request a copy of the evaluation report. Stated previously on page 8, initial evaluation is expected within 24-48 hours of date of service.
- The Operations team will request weekly attendance records for our injured workers, including any future visits scheduled, or explanations if a patient has discontinued treatment.

CLAIMS SUBMISSION AND PAYMENT POLICY

Scheduling & Authorization Process

Patients may be scheduled for services at your facility through a direct call from Streamline, a referring physician, an adjuster, or a nurse case manager. When scheduling, these parties should identify the patient as a Streamline referral.

- Within 24 hours of scheduling a Streamline patient, you will receive an authorization form via fax, confirming:
    - Ordered services
    - Patient demographics
    - Referring physician details
    - Streamline payer information
    - Contracted rate

Important Billing Guidelines

- The Workers' Compensation industry does not issue identification cards. As a result, injured workers may not fully understand Streamline's role and may mistakenly instruct you to bill their employer's workers' compensation carrier.
  → PLEASE DO NOT follow the injured worker's billing instructions if the referral is identified as a Streamline case.
- Electronic Claims Submission (Preferred Method):
  Jopari Payer ID: J4481 – Electronic submission accelerates processing and enhances claim visibility.

Additional submission methods:

- Jopari
- Provider Connect https://providerconnect.streamlineworkcomp.com/login
- Email: ptbill@streamlineworkcomp.com
- Web Portal: Document Drop
- Fax: 904-944-4169
- Mail: Streamline, P.O. Box 21069, Roanoke, VA 24018

Claim Submission Policy

If your facility utilizes an external billing service, please share this information with them. To request a copy of this manual for your billing service, contact Provider Relations at providerrelations@streamlineworkcomp.com or call 855-877-9292.

Billing Compliance & Submission Requirements

- Balance billing of patients is strictly prohibited under state laws and Streamline policy. Implement appropriate measures to ensure compliance.
- DO NOT send bills to the workers' compensation carrier or employer for Streamline patients. Doing so violates your contract with Streamline Imaging and creates billing confusion.
- Providers must submit claims to Streamline within 30 days of the date of service.
- Claims should be submitted using a CMS (formerly HCFA) 1500 or UB-04 form and must include:
    - ICD-10 codes
    - All appropriate CPT codes with non-discounted pricing
    - Patient's date of birth
    - Patient's claim number
    - Referring physician's and rendering therapist's name & NPI

Claims Processing & Payment

- Upon receiving a clean claim, Streamline will process it according to the provider's contracted reimbursement rate and payment timeframe.
- Payments will be made within the timeframe specified in your contract. For example, if the contract stipulates 45 days, payment will be processed within 45 days of receiving a clean CMS/HCFA 1500 form—not 45 days from the date of service.
- If a claim is inadvertently billed to the workers' compensation carrier and payment is received, immediately contact Streamline's Billing Department at 855-877-9292 to initiate the refund process.
- Explanation of Payments (EOPs) are sent with reimbursement checks, while Explanation of Denials (EODs) are sent separately to the billing address listed on the CMS/HCFA 1500 form.

For payment inquiries or appeals, contact Streamline's Billing Department at 855-877-9292.

BILLING GUIDELINES

The following guidelines provide healthcare providers with essential instructions to ensure that Workers' Compensation claims submitted to Streamline are processed accurately and promptly. Streamline offers multiple convenient methods for claim submission:

Electronic Claim Submission Methods

- **Jopari:** Submit bills electronically through Jopari using Payer ID J4481. Electronic submissions expedite processing and enhance visibility into claim statuses.
- **Provider Connect:** This portal allows Streamline Providers to perform self-service functions, make inquiries, and upload/download documents. Provider Connect link: https://providerconnect.streamlineworkcomp.com/login. To register, contact Provider Relations at providerrelations@streamlineworkcomp.com.
- **Website Upload:** Visit Streamline Work Comp, navigate to the Provider Documents tab, complete the required fields, and upload the necessary documents.

Claim Submission Requirements

- **Include Supporting Documentation:**
    - Clearly document time spent with the patient during therapy sessions. For example, if billing for 2 units of CPT code 97110, the documentation should confirm that more than 22 minutes were spent performing the therapy.
    - Attach an Activity Log or flow sheet.
    - Ensure the billed units correspond to the time spent with the patient.
    - Follow state-specific Workers' Compensation billing codes for services such as Functional Capacity Evaluations (FCE), Work Hardening/Conditioning, and Impairment Ratings.
    - Obtain and submit appropriate authorizations for billed services and visit counts.
    - For claims involving an "L" code (splinting/brace), an itemized cost statement must be provided.
- **Signatures:**
    - Bills and supporting notes must be properly signed.
    - Physical and Occupational Therapists must sign relevant documentation.

- Whomever signs the bill must also sign or countersign the supporting documentation. **Ex**: if a PTA signs claim and/or note, therapist must also sign.

- **Timely Submission:**
  - Submit claims within the numbers of days written in the contractual agreement of the Date of Service (DOS). Delays beyond this period may result in claim denial for untimely filing.
  - A bill without proper supporting documentation is not considered received and will be denied.

- **Credentialing Requirements:**
  - Ensure that a valid W9 and credentialing paperwork are on file before submitting your first claim. Claims will be denied if a current W9 is not on record.

Common Reasons for Claim Denials

- **Coding and Billing Errors:**
  - **Bundled/NCCI Edits:** Claims must adhere to Workers' Compensation state guidelines and National Correct Coding Initiative (NCCI) rules. If billed codes are not separately reimbursable under NCCI edits, they will be denied.
  - **Patient Identification Issues:** Ensure the referral/claim number provided at scheduling is included on the claim form, along with accurate patient name and date of birth.
  - **Diagnosis Mismatch:** Diagnosis codes must align with the treatment provided. For example, a lumbar service claim cannot be submitted with a knee pain diagnosis code.
  - **Duplicate Line Items:** If the same CPT code is billed twice for the same DOS without an appropriate modifier (e.g., RT, LT), one line may be denied as a duplicate.
  - **Exceeding Service Limits:**
    - Initial evaluations are only allowed once per injury.
    - Some states limit the number of allowable modalities per referral or claim.
    - Certain therapy services have unit restrictions per session or claim lifespan.
  - **Incorrect CPT Codes/Modifiers:**

- Functional Capacity Evaluations (FCE) may have unit caps (e.g., 8, 12, 16, or 20 units, depending on the state).
- Work Hardening (97545) is billed per 2-hour session with a single unit. Additional time should be billed under CPT code 97546 in 30-minute increments.
- Evaluation codes should be billed as one unit. A second initial evaluation may be downcoded or denied.
- CPT codes billed on separate lines without a modifier may be denied as duplicates.
- Services identified by the National Correct Coding Initiative (NCCI) as eligible for separate reimbursement when billed together should be appropriately modified to reflect their distinct and separate nature. However, if the services are not separate and distinct, they should not be billed with a modifier and will not qualify for separate reimbursement.
- **GP vs. GO Modifiers:**
    - GP modifier is used for Physical Therapy services.
    - GO modifier is used for Occupational Therapy services.
    - A mismatch between provider type and modifier may result in denial.
- **Units and Time Alignment:**
    - Most states follow the **8-minute rule**:
        - 1 unit = 8 to 15 minutes.
        - 2 units = 22 to 30 minutes.
    - Billing must reflect actual treatment time.
- **Incorrect DOS:** The date on the documentation must match the billed Date of Service.
- **Lack of Authorization:** Some treatments require prior authorization based on state-specific Workers' Compensation fee schedules. Example: Dry Needling is not covered in many states.

- **Non-Compensable Services:** Services not covered under Workers' Compensation or claims that have been settled and closed may be denied.
- **Multiple Procedure Payment Reduction (MPPR) Rule:**
  - Varies by state.
  - Typically, the highest reimbursing procedure is at 100% of the FS, **less your contracted rate**, with subsequent services reduced according to state guidelines.
- **Telehealth Services:**
  - Must have prior authorization.
  - Unauthorized telehealth visits will not be reimbursed.

By following these guidelines, providers can ensure accurate and timely processing of Workers' Compensation claims, reducing the likelihood of denials and payment delays. For further inquiries or assistance, please contact Provider Relations at providerrelations@streamlineworkcomp.com.

CLAIMS APPEALS GUIDELINES

Administrative Denials & Appeals Process

Streamline is committed to ensuring transparency in administrative denials and will provide clear communication regarding the reason for denial, as well as the necessary actions to resolve it. Patients may not be billed for denied procedures.

Provider Responsibilities in the Appeals Process

Providers have the right to appeal adverse benefit determinations. To initiate an appeal, providers must:

- Review the Explanation of Denial to understand:
    - The specific reasons for the adverse determination.
    - Any required documentation needed for appeal review.
- Contact Streamline's Billing Department for assistance with payment appeals.
- Submit all appeal-related information promptly to ensure timely resolution.

Streamline's Responsibilities in the Appeals Process

Streamline will:

- Provide a written explanation of the denial, including detailed reasoning.
- Identify specific documents or records required to support a favorable determination.
- Conduct a thorough review of all submitted appeal materials.
- Respond to appeals within 60 days.
- Inform providers of additional appeal options if the initial determination remains unfavorable.

How to Submit an Appeal

When submitting an appeal, please send a letter on company letterhead, including:

- Patient's Name, Date of Birth, and Claim Number
- Date of Service & CPT Code(s) in question
- Date of denial and reason for denial
- Supporting documentation justifying claim reconsideration

- Copies of the denial notice and the original claim form

Appeals should be sent to:

Mail:
Streamline
P.O. Box 21069
Roanoke, VA 24018

Email:
ptbill@streamlineworkcomp.com

Reconsideration & Corrected Claims

If you disagree with a payment decision, you may file a reconsideration request by submitting:

- A cover letter or Reconsideration Form outlining the reason for dispute.
- The claim form with Condition Code 7 in form field 22 (Resubmission Code).
- The Explanation of Benefits (EOB) received with the disputed payment.
- Any supporting documentation to justify the reconsideration request.

Submitting a Corrected Claim

If you need to submit a corrected claim, include:

- A cover letter or Reconsideration Form detailing the correction.
- The Corrected HCFA with Condition Code 7 in form field 22 (Resubmission Code).
- The EOB from the original claim decision.
- Any supporting documentation to justify the correction.

PROVIDER SUPPORT AND CONTACT INFORMATION

For assistance, contact Streamline between 8:00 AM – 5:00 PM EST at 855-877-9292 or via the appropriate department below:

Scheduling & Authorization

Email: referral@streamlineworkcomp.com
Fax: 855-877-9595
Phone: 855-877-9292 Option 1

Assistance with:

- Scheduling issues
- Appointment changes or reschedules
- Patient No Shows
- Authorization form discrepancies
- Appointment authorization requests

Provider Relations

Email: providerrelations@streamlineworkcomp.com
Fax: 855-877-9595
Phone: 855-877-9292

Assistance with:

- Demographic updates (e.g., Tax ID, Business Name, Address, Contact Details)
- Adding or closing a facility
- Temporary facility closures (e.g., construction, equipment upgrades)
- General operational inquiries
- Credentialing

Evaluations & Progress Notes

Fax: 904-944-4176

Providers must:

- Submit evaluation and progress notes within 48 hours of the procedure.
- Utilize the Provider Connect for electronic report submissions.

Billing Inquiries

Provider Connect: https://providerconnect.streamlineworkcomp.com/login

Email: ptbill@streamlineworkcomp.com
Fax: 855-877-9595

Assistance with:

- Claim status updates
- Refund process
- Medical claim appeals

When inquiring about claim status, please provide:

- Patient's Name & DOB
- Date of Service & CPT Codes
- Claim Number

POLICY AND COMPLIANCE DISCLAIMER

The guidelines outlined in this manual are part of the contractual agreement between Streamline and its providers. Streamline reserves the right to modify workflow processes and policies as necessary to:

- Accommodate client needs
- Ensure compliance with all applicable laws and regulations

Updated versions of this manual are available upon request. Please contact providerrelations@streamlineworkcomp.com to request a copy.