HealthSmart®

# Welcome to MyDecision™

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# Welcome to the MyDecision™ Program

HealthSmart is delighted to welcome you as a Participating Provider in the MyDecision™ bundled payment program.

MyDecision™ empowers self-funded employers, employees and families with decision support tools that direct them to high quality providers and not just the lowest cost alternative. It combines the following three elements:

1) Price and quality transparency; 2) Bundled price methodology; and 3) Member engagement and guidance.

## Advantages of being a participating provider:

- Claims are paid within 10 days business days from receipt.
- Employers must modify benefit plan design to pay 100% of the bundled rate leaving no outstanding amounts to collect.
- Members and Providers are given a personalized advocate to guide them into MyDecision™ providers.
- Concierge level services assist them through the entire episode of care: patient throughput is streamlined.
- MyDecision™ program is designed for narrow provider access to maximize patient/procedure volume.
- Allows for providers to publicize and promote best-in-class quality metrics to MyDecision™ members.
- Designed to engage members prior to healthcare services being requested.
- The development of the MyDecision™ provider footprint supports our mission to provide affordable health care solutions to employer groups and promote the wellness of our members—your patients.
- Our brand promise can only be accomplished by collaborating with our providers and continuously striving to develop a quality-based provider program.

# Introduction

This MyDecision™ Provider Manual (the "Provider Manual") includes information about policies and procedures of MyDecision™.

HealthSmart partners with a select list of the highest quality Providers to reduce healthcare costs and manage members with dignity and respect. We appreciate your cooperation and compliance with the policies and procedures outlined in your Provider Agreement and this Provider Manual.

The requirements, policies and procedures established in the Provider Manual are a contractual obligation as acknowledged in your Provider Agreement with MyDecision™. HealthSmart understands that making material changes to the manual can adversely affect a Provider and Eligible Persons experience and therefore it is our intent to keep operational requirements static and would make necessary announcements to its provider network in the instance we make material changes. HealthSmart, however, may update the Provider Manual as technology, procedures, policies and programs change.

# Core Product Attributes

- ✓ Concierge Member and Provider Engagement
- ✓ Integrated with Utilization Management
- ✓ Active Redirection to MyDecision™ Providers
- ✓ MyDecision™ Referral Management Portal
- ✓ Buying Decision Tools
- ✓ Price Transparency
- ✓ Reporting

# Our Brand Promise

MyDecision is backed by the largest independent TPA,
Provider Network and Care Management vendor in the nation

- MyDecision is a core service offering and market leader with proven results
- Fully owned and integrated utilization management services
- MyDecision is not a "supplemental" or "passive" program, but an active program with expert Advocates, providing real-time best-in-class concierge service with a 92% success rate of directing members to high quality, low cost settings
- Access to providers is local, so members do not have to travel long distances for care
- All providers are credentialed to NCQA standards and must maintain the highest quality outcomes at the procedure level
- Customizable, with the ability to share savings with members in several ways
- Already integrated within the Healthcare Bluebook transparency platform – a strategic partner since 2014
- We bring our experience with clients from 100 to over 93,000 employee lives using MyDecision.
- Proven incremental plan savings of 4%-7% over the prevailing PPO prices

# Quick Reference Guide for Providers

| | |
|---|---|
| **MyDecision™ Advocacy Team** | Phone: 844-289-9963<br>Fax: 806-473-2799<br>Email: MyDecison@HealthSmart.com |
| **Identifying and Registering MyDecision™ Members** | Participants will present an E-Ticket referral form that includes the following information:<br>• E-ticket authorization number<br>• Group Name<br>• Patient Name, DOB<br>• Patient Contact Information: Phone and e-mail<br>• Provider name and demographics<br>• Diagnosis and procedure codes<br>• MyDecision™ benefit summary<br>In addition to the participant presenting an E-Ticket, the Referral Coordinator will transmit an E-Ticket to the Provider prior to the member's appointment. The E-Ticket is valid for 30 days from the date on the document and must be presented at the time of service.<br>This benefit **only** applies to plan members eligible for participation in the MyDecision™ Program. The E-Ticket is not a guarantee of payment. Members **should not** present their medical ID card on the date of service. |
| **Pre-Certification of an Episode of Care** | Phone: 877-202-6379<br>Secure Fax: 214-574-2355<br>Secure e-mail: hsprecert@healthsmart.com<br><br>Our Referral Coordinators try to be proactive in obtaining the Authorization number for the accepting provider. If, however, Pre-Cert is required, a provider can complete and submit the HealthSmart Care Management's "Prior Authorization Form" along with clinical notes for IP and OP pre-cert requests. |
| **LeadingReach Portal** | Register on line. This is a HIPPA compliant secure web-based portal for streamlined information exchange with the MyDecision™ Referral Coordinators.<br>https://app.leadingreach.com/launchpad<br>HealthSmart covers the license fees on behalf of our program providers. |
| **Electronic Provider Claims Submissions** | Preferred method: ASC X12 5010 submitted to MyDecision™.<br>**Payor ID: 18840** |

# Contact Information

| | |
|---|---|
| **MyDecision™ Provider Solutions Unit** | Provider Relations Representative<br>Phone: 405-241-4811<br>pr.mydecision@healthsmart.com |
| **MyDecision™ Claims** | Via Email: invoicesokc@healthsmart.com<br>ASC X12 5010 submitted to MyDecision™: **Payor ID: 18840** |

# MyDecision™ is Simple

- The MyDecision provider will receive referrals or orders via Leading Reach, Fax, or email.
- If case is accepted, the provider will contact the member and schedule the appointment or procedure.
- Provider notifies the MyDecision™ Advocacy Team if case is not accepted, or when a member is scheduled.
- It is the Provider's responsibility to ensure that any necessary clinical pre-certification is obtained prior to performing a medical procedure.
- An E-ticket is issued by the MyDecision Advocacy Team for scheduled services and is required for throughput and claims processing.
- Provider performs procedure and bills according to Claims, Billing & Collection Procedures.

# LeadingReach

LeadingReach is our web based referral management portal. MyDecision™ Providers and Member Advocates communicate by sending and receiving messages and documents to facilitate patient care. Providers are to ensure all necessary information (Medical records, scheduled appointments, etc.) is provided for offices and MyDecision™ Advocates during the referral process. If you have any questions or concerns, please send a detailed email to pr.mydecision@healthsmart.com.

## Integrated Process Overview

1. Pre-certification request is received, reviewed and determination of medical necessity is made
2. Upon medical necessity approval, request is reviewed for determination of a qualifying Bundled Service
3. If request is for a qualifying Bundled Service, referral is made to MyDecision™ Advocate team for member outreach
4. Member selects provider, Advocate works with provider selected to schedule appointment, E-ticket is issued to both provider and member
5. Advocate is available to member to assist with any issues during the episode of care and post procedure follow-up

## Direct Member Contact Process Overview

1. Upon member outreach to MyDecision™ Advocate team member eligibility is verified
2. Member is educated on the Bundled Service benefit and providers eligible to perform test/procedure if requested is a qualified service
3. If prior authorization is required member is instructed to outreach to provider so they may obtain required approval
4. Member selects provider, Advocate works with provider selected to schedule appointment, E-ticket is issued to both provider and member
5. Advocate is available to member to assist with any issues during the episode of care and post procedure follow-up

# Sample E-Ticket

MyDecision™

**E-Ticket for MyDecision Program** ***MyDecision Payor ID: 18840**

**Date Authorized: July 17, 2018** **E Number:** ***Group ID:**

E-Ticket Authorization Number:

Group Name:

Member Name:

Patient Name:

DOB:

Phone Number:

Mailing Address:

Email Address:

Provider Name:

Phone Number:

Provider Address:

Procedure Date:

Procedure Code:

Facility:

Benefits: 100% Covered Benefit

Questions? Contact Us: MyDecision Advocate
844-289-9963
mydecision@healthsmart.com

**PROVIDERS:** ***MyDecision Payor ID** and ***Group ID** are required on all claims submitted. Claims submitted without this information may result in non-payment of claim and require resubmission of a corrected claim to obtain payment.

**The E-Ticket is valid 30 days from the date on this document and must be presented to the provider at the time of service. Failure to schedule an appointment within 30 days voids the E-Ticket authorization.**

1. You must have an E-Ticket for **every** date of service for the $0 cost benefit to apply.
2. Failure to present an E-Ticket at every date of service, **will result in your claim being subject to deductible and co-insurance under your regular Plan benefits.**
3. **Please be advised not all services are available under the MyDecision Program. Each program provider agreement is unique.**

**Please contact your MyDecision Team to confirm which services are included in the bundled rate with the provider you select for your medical needs.**

**PLEASE NOTE: This benefit only applies to plan members eligible for participation in the MyDecision Program. This E-Ticket is not a guarantee of payment. Members should NOT present their medical ID card on the date of service.**

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# Network Credentialing Guidelines

HealthSmart maintains the highest quality provider network. This commitment involves credentialing and re-credentialing of each provider in accordance with the standards established by National Committee for Quality Assurance (NCQA). All providers are required to complete a Provider Application and Agreement. Provider application may be obtained by contacting HealthSmart, or the following web site: www.healthsmart.com. All requested information must be received to process the application.

Verification of each state license and a query of the National Practitioner Data Bank will be used to determine whether registration has been suspended or revoked. Malpractice insurance will be verified. Pending, settled, closed or awarded cases may be reviewed by a peer committee. Complete malpractice information must be provided on each malpractice case/suit/settlement (s) that a Participating Provider was involved in for the past five (5) years for initial credentialing or the past three (3) years for re-credentialing.

Provider liability Insurance minimum requirements are based on state and industry standards per policy year for ALL HealthSmart Providers. Participating Provider shall also insure that his/her employees maintain the applicable general and professional liability insurance coverage.

The following information must be active (as applicable) and unrestricted:

- State License
- DEA
- Controlled Substance Certificate
- Malpractice Insurance Certificate

# Provider Data Updates

## Changes and Additions of Providers, Facilities and Locations

This process applies to sites added through an existing Provider Agreement, as well as address or other demographic changes regarding facility and/or billing addresses.

The information contained in our provider database is shared with clients and is displayed in provider directories and on our website. This is the best way to share your organization's locations to the members we represent. In order to make sure that our clients have access to the most current information, we ask that multiple site providers update us routinely. Provider demographic updates can be done easily by emailing pr.mydecision@healthsmart.com. Site additions and changes can also be submitted to MyDecision™ via regular mail, email or fax. MyDecision™ updates its system within days of receiving documentation from the provider. If the Tax ID number is new or just changing you will also need to submit a copy of the new W-9 with all updated documentation.

We can coordinate monthly or quarterly updates where appropriate for larger organizations, using an Excel format (format requirements displayed on the following page).

## Terminations of Sites and/or Providers

All provider or site terminations require a written notice from the provider on the provider practice letterhead. Your written notice can be submitted to MyDecision™ via mail, email or fax, and will be processed according to your MyDecision™ Provider Agreement. For those providers submitting routine Microsoft Excel updates, there are columns for Termination Date and Reason.

If a site or office has closed the termination will be processed upon receipt of your notice.

# Claims, Billing & Collection Procedure

## 5010 Compliant

Provider shall submit to HealthSmart Clean Claims electronically on a UB-04, CMS-1500 or successor form(s) (i.e. 837i and 837p) to our dedicated Payor ID: 18840

## Non-5010 Invoices

If, despite best efforts, Participating Provider cannot submit claims electronically, please send your Non-5010 Invoices to invoicesokc@healthsmart.com.

# EOP Example

HealthSmart
Get Better

1 HealthSmart Benefit Solutions
7725 W Reno Ave, Suite 397
Oklahoma City, OK 73127

Forwarding Service Requested

AADADATADADDDFDFDADD4FTTF4FDDDDFFDTTTADAFTTTT4TDFFADDDDTTFFDTFDFAD

**********ALL FOR AADC 730

2 Example Establishment
PO BOX 000
Oklahoma City 73134

35

J6C0 [11,354] 1 of 2

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**Remittance Advice**

[-CC]

**Customer Service**

3 If you have questions, please call customer service at 405-848-1975 or 800-825-3540 or visit www.maa-tpa.com

**Participant Information**

4 Group: ABC Company
5 Group No.: 000011
6 Location No.: 001
7 Location: ALL EMPLOYEES
8 Plan No.: XX00001
9 Paid Date: 07/21/2017

10 Claim#: 00000000-00
11 Patient: JOHN DOE
12 Provider: Example Provider
13 Enrollee Id:
14 Enrollee: JOHN DOE
15 Patient#: 800000000000
16 Reference #: 00675548

| 17 Dates of Service | 18 Proc. Code | 19 Amount Billed | 20 Not Covered | 21 Rmk Code | 22 Discount Amount | 23 Allowed Amount | 24 Deductible Amount | 25 Co-pay Amount | 26 Covered Amount | 27 Paid At | 28 Payment Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 07/07-07/07/2017 | U0490 | $1,291.17 | $0.00 | | $0.00 | $1,291.17 | $0.00 | $0.00 | $1,291.17 | 100% | $1,291.17 |
| 07/07-07/07/2017 | U0490 | $1,291.17 | $0.00 | SM | $182.34 | $1,108.83 | $0.00 | $0.00 | $1,108.83 | 100% | $1,108.83 |
| 29 Column Totals | | $2,582.34 | $0.00 | | $182.34 | $2,400.00 | $0.00 | $0.00 | $2,400.00 | | $2,400.00 |

30 **Patient's Responsibility: $0.00**

31 **Remark Code Description**

SM MYDECISION PROVIDER DISCOUNT. YOU DO NOT OWE THIS AMOUNT.

32 **Important Information**

If you disagree with this determination, you must submit proof that the claim for benefits is covered and payable under the Plan's provisions, including (a) all facts and theories supporting your claim, (b) a statement of the reason(s) for disagreement with the handling of the claim, and (c) any material/information that indicates that the claim does not fall within the referenced Plan provision. Information regarding your right to appeal an adverse benefit determination is attached. The appeal provisions applicable to your claim are more fully set out in the Plan Document for your Employer Group Medical Plan. For additional questions regarding the claimant's appeal process, please call (405) 848-1975 or (800) 825-3540 and speak with a customer service representative.

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Get Better

Bank of Example

39-13
1030

00000000

DATE
07/21/2017
Void after 90 Days

VOID

PAY ***TWO THOUSAND FOUR HUNDRED DOLLARS AND 00 CENTS***

AMOUNT
**********$2,400.00

TO THE ORDER OF
Example Establishment
PO BOX 000
Oklahoma City 73134

Claim #: 00000000-00
Patient #: 800000000000

Authorized Signature

HealthSmart

# Understanding your EOP

Below is a description of your Explanation of Payment (EOP). The numbers correspond with the numbers on the same copy of the EOP (see the last page for an example of an EOP).

1. Claim Processing Office: this is the location of the claims processing office. You can write to customer service at this location.
2. Address: the name and address where the EOB is being mailed.
3. Customer Service: number to call with questions regarding the claim.
4. Group Name: the name of the patient's Group (in most cases, this is the patient's employer).
5. Group Number: the identification number for the patient's Group. Please refer to this number if you call or write about your claim.
6. Location Number: the number assigned to the patient's location within the Group.
7. Location Name: the name or description of the location.
8. Plan Number: the identification number for the plan of benefits.
9. Paid Date: if a check was issued, the date it was issued.
10. Claim Number: the unique identification number assigned to this claim. Please refer to this number if you call or write about this claim.
11. Patient: the name of the individual for whom services were rendered or supplies were furnished.
12. Provider: the name of the person or organization who rendered the service or provided the medical supplies.
13. Enrollee Id: the name of the covered employee.
14. Enrollee: the name of the individual for whom services were rendered or supplies were furnished.

15. Patient #: patient social security number (last 4 digits only) or identification number. Refer to this ID number if you call or write about the claim.
16. Reference Number: the claim system check number, for reference purposes only.
17. Dates of Service: the date(s) on which services were rendered.
18. Procedure Code: the Current Procedural Terminology (CPT) codes listed on the provider's bill.
19. Amount Billed: the charge for each service.
20. Charges Not Covered: charge that is not eligible for benefits under the plan.
21. Remark Code: code relating to the "Charges Not Covered" amount. Also used to request additional information or provide further explanations of the claim payment.
22. Discount Amount: identifies the savings received from a Preferred Provider Organization (PPO), if applicable.
23. Allowed Amount: maximum allowed charge as determined by patient's benefit plan after subtracting Charges Not Covered and the Provider Discount from the Amount Billed.
24. Deductible Amount: the amount of allowed charges that apply to patient's plan deductible that must be paid before benefits are payable.
25. Copay: the amount of allowed charges, specified by the patient's plan, that patient must pay before benefits are paid.
26. Covered Amount: eligible charges considered under the patient's plan
27. Paid At: the percentage of the Covered Amount that will be considered under the patient's benefit plan.
28. Payment Amount: benefits payable for services provided.
29. Column Totals: the sum of each column.
30. Patient Responsibility: after all benefits have been calculated, this is the amount of the enrollee's responsibility for this claim.
31. Remark Code Description: additional explanation of the Remark or Discount Code will appear in this section.

32. Important Information: statement explaining your entitlement to a review of the benefit determination on the Explanation of Benefits (EOB). This information varies according to each plan

## Provider Expectations

**Quality Assurance:** HealthSmart may implement a program of utilization, quality, assurance, and peer review based upon standards established by Federal and State law, the purpose of which is to promote adherence to accepted medical treatment standards.

**Timely Filing:** Such claims/invoice must be submitted within the time specified in the members Plan Document and Summary Plan Description.

**Claims Requirements:** Claims shall include, at a minimum, the following to be considered clean and complete: (i) Provider name; (ii) Provider tax identification number; (iii) identifying patient information; (iv) diagnosis; (v) date of service; (vi) group number; and (vii) other information as required by HealthSmart.

**Medical Records:** Medical records information for Participants will be maintained and made available to the Plans third-party administrator for the purposes of assessing quality of care, medical necessity and the time of each initial visit for a course of treatment, and to release such records to HealthSmart.

**Non-Bundled Procedures:** Providers to immediately contact the MyDecision™ Advocacy Team for procedures that are not listed as an approved or qualified Bundle

**Non-Discrimination.** Providers shall not discriminate in the delivery of Covered Services to Members on the basis of race, religion, national origin, sex, marital status, sexual orientation, health status (except as directly related to medical treatment), disability, source of payment for services, or age.

# Glossary

"Bundled Service": is a and delivery method that folds the multiple components of a specific episode of care into a single reimbursable element.

"Bundled Rate": is a predetermined all-inclusive reimbursement amount for an Episode of Care as set forth in the Provider Agreements

"Episode of Care": is a defined package of covered services related to a specific diagnosis or medical procedure with a defined beginning and endpoint of care.

"Advocate": is a dedicated subject matter expert whose role is to serve as an advocate for the member and Provider throughout the episode of care.

"Healthcare Bluebook": is a web-based application to locate MyDecision™ providers and see variations in prices and quality rankings for providers and services.

"Provider Relations Representative": is a dedicated provider relations representative who is the providers main contact for service related matters, including but not limited to claims and billing inquiries, scheduling issues or concerns, contract and agreements, and provider feedback.