Health Network Provider Manual

Organized to Care for the OSA Patient

For assistance:

Contact your Network Representative or call:

800-570-7414
Billing: Ext. 43
Shipping: Ext. 44
Provider Network: Ext. 46
SyncCare™ Support: Ext. 47

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I. Network Management Program Overview

ProAct Health Solutions, Inc. coordinates healthcare services for the treatment of Obstructive Sleep Apnea (OSA) that is currently focused in the Osceola County Florida area but is planned to expand nationwide. ProAct employs a fully integrated model for the identification and effective treatment of OSA. To provide these services ProAct has developed and maintains a Specialty Provider network of qualified Dentists who are trained to fit oral appliances for the treatment of OSA. Criteria for network participation focus on consumer needs, ensuring quality of care and service, and takes into account meeting the business needs of the organization.

A. Health Services[1]

ProAct maintains a network of qualified dentist who are trained to manage the full continuum of care for patients with Obstructive Sleep Apnea ("OSA"). Services include screening and assessing existing practice patients for the disease, arranging for testing and diagnosis of those with positive assessments, arranging for the treatment of those determined, by a diagnosing Sleep Specialist, to require a Positive Airway Pressure device, and, for those determined to require a Mandibular Advancement Device ("MAD"), fitting of the device.

There are approximately 130 possible codes for treating OSA, approximately 80 of which apply to the dental office. All codes are medical; and they include Assessment Services, Dental Services (relating to the MAD), Care Management, and Appliance Repair.

B. Population Served[2]

ProAct has developed and maintains a network of providers to serve consumers who reside in the Osceola County Florida area. As of 2012, there were 287,416 people, and 92,526 households residing in the county. The racial makeup of the county was 38.2% Non-Hispanic White, 13.0% Non-Hispanic Black or African American, 0.7% Native American, 3.0% Asian, 0.2% Pacific Islander, and 2.5% from two or more races.

36% of the households had children under the age of 18 living with them, 56% were married couples living together, 13% had a female householder with no husband present, and 26% were non-families. The average household size was 2.79 and the average family size was 3.18.

The median income for a household in the county was $39,214, and the median income for a family was $44,061. About 13% of the population is below the poverty line, including 14.70% of those under age 18 and 8.60% of those age 65 or over.

C. Provider Network Adequacy

ProAct seeks to ensure that their provider network consists of enough providers to provide needed services to the target population. This is assured by monitoring and evaluating the access and availability of participating providers. ProAct considers provider access and

availability as a key performance indicator for the organization. ProAct routinely monitors the following metrics and sets performance goals to ensure network adequacy:

D. Network Accessibility

ProAct has conducts geo access mapping of its service area to ensure target consumers have access to dental outpatient services within 30 miles/30 minutes of their residence. ProAct sets the benchmark of 95% of target consumers will have outpatient and acute services within those parameters.

E. Network Availability

ProAct gages provider availability through the percentage of providers who have the availability to accept and readily (within 14 days of appointment request) treat new patients. Providers are contracted to inform ProAct when they cannot meet this availability standard. ProAct sets the benchmark of 95% of the provider network are accepting new patients.

II. Network Performance Monitoring and Oversight[3]

The Quality Management Committee (QMC) provides oversight of network access and availability by reviewing the Network Adequacy reports. If benchmark performance is not attained for 2 consecutive quarters the QMC will institute a corrective action plan. When the implementation of a corrective action plan still does not resolve the specific issue(s), the QMC develop a formal quality improvement project (QIP) to address and correct specific network access or availability issues.

III. Criteria and Process to become a Participating Provider[4]

Providers accepted into the ProAct network must be fiscally stable, ethical, adhere to all laws, rules and regulations, be committed to accessibility, including adherence to all local and state health and safety requirements.[5]

A. The provider must possess the expertise through licensure, education, training, and experience with a culturally diverse population as required, to perform the specific service(s) for which they are contracted.[6]
B. Contracted services should support evidence-based practice.[7]
C. Providers must have:
    i. State licensure including current license(s) and history of license(s) in all jurisdictions, where applicable
    ii. Evidence of a current Drug Enforcement Agency (DEA) certificate or state controlled dangerous substance certificate, if applicable
    iii. Correct & complete certificate of insurance that meet required limits as outlined in the contract

Applications are received from providers to join the ProAct provider network and are reviewed as defined in the ProAct Credentialing Plan to ensure that the provider meets these

requirements. Each individual application is considered individually and the business needs of ProAct, as well as quality and service needs are taken into account with each application submitted.

A. Credentialing Process:

Dental practices and/or dentists, who would like to apply to be a participating provider, must first go to the Participation Application Request Tab, complete and submit the request. A ProAct Representative will contact you to review all program requirements. If you would like to proceed, they will assist you in completing the initial SyncCare™ system set up, including submission of all credentialing information required for processing.

Once the application has been completed, attestations signed, and our Credentialing Department notified, the formal credentialing process begins. This process includes primary source verification of key elements of your application. Should incomplete, inaccurate or conflicting information be identified, the applicant will be contacted and given an opportunity to correct the information and resubmit it to the Credentialing Department. It is the applicant's responsibility to work with the organization that reported the inaccurate, conflicting or incomplete information to get it corrected. The applicant, at any time during the credentialing process, may also contact the Credentialing Department to check the status of their application. Once the verification process is completed, the applicant will be notified within 10 business days of the recommendation of the Credentials Committee.

Credentialing typically requires 30 to 90 days. Upon approval, you will be notified by the ProAct Representative, who will make arrangement to assist you with the remainder of the system set-up and staff in-service.

IV. Provider Communication and Relations

ProAct implements a participating Provider Relations Program to ensure providers receive necessary information and communication. ProAct ensures providers have access to all statutes, rules, regulations, guidelines, policies, operational procedures, and recommendations necessary to fulfill their obligations as providers. ProAct provides this communication through the following:

- New Provider Orientation
- ProAct Website
- Provider Portal to the SyncCare™ System
- Provider Newsletters and Email Bulletins

In addition, the ProAct Provider Relations Department is available to address provider's needs and ensures that providers have the support and technical assistance necessary to deliver quality services. All provider manuals and orientation material are posted and available for download in the secure participating provider logon section of this website. When requiring

assistance with network issues, providers are encouraged to contact their Network Representative or contact Network Assistance at 800-570-7414 Extension: 46.

Participating provider input is welcomed. Providers are encouraged to contact their Network Representative with input or to complete a formal comment or suggestion on the Provider Input Tab in the secure participating provider logon section of this website. All formal inputs will receive a response within 1 business day.

V. Provider Representation

ProAct maintains mechanisms for participating providers to give meaningful input, suggestions and guidance to the organization regarding clinical service improvement and provider payment policies. Participating Provider are always welcome to provide input via the website or directly to any ProAct staff. Additionally, ProAct encourages involvement of Participating providers on its committees. ProAct seeks to invite and involve an adequate number and a variety of provider types who offer the services most often required by consumers in organizational committees.[8]

ProAct also encourages provider involvement and seeks to incorporate provider input and perspective in network management activities that address clinical and provider payment policies.[9] Providers have the opportunity to provide input and their clinical expertise into the clinical program and other clinical content materials. ProAct has participating provider membership on their Credentialing Committee and Quality Management Committee. Any participating provider who would like to be involved in a ProAct committee or provider input into ProAct management decisions can contact their Network Coordinator for more information.

Additionally, ProAct gathers the Practice Advisory Council (PAC) at least annually. The PAC is attended by participating providers to provide input into the network management program and share their suggestions and guidance on how to improve the ProAct provider network.[10] The PAC reports all recommendations back to the QMC for consideration. All PAC meeting dates and agendas are posted on the ProAct website. Any participating provider who would like to attend should contact their Network Coordinator for further meeting information and invitation.

Participating provider input is always welcomed. Providers are encouraged to contact their Network Representative with input or to complete a formal comment or suggestion on the Provider Input Tab in the secure participating provider logon section of this website. All formal inputs will receive a response within 1 business day.

VI. Provider Orientation Materials[11]

ProAct has an interactive provider orientation program for all new participating provider offices. Network/Implementation Coordinators provide direct orientation to all new provider offices. This orientation includes the following:

- Organizational Overview
- Demonstration of the Patient Portal
- Training on Policies and Processes
- Introduction to the ProAct website

These materials are posted on the ProAct website for on-going provider reference.

VII. Updates on Network Activities[12]

For significant changes ProAct sends e-mail updates to all participating provider offices in addition to posting updates on the website. The purpose of the update e-mail is to help ensure providers are informed of significant network changes and news. Significant changes include any changes in fee schedules or contracting provisions.

VIII. Changes in fee schedules or contracting provisions[13]

ProAct maintains an active payer contracting effort with the objective of maximizing the number of patients who can have OSA treated by Network Providers as an in-network benefit rather than an out-of-network benefit, requiring a higher patient payment portion.

For participating providers, ProAct publishes frequently updated provider rate schedules for:

- Private pay;
- Out-of–network, and
- In-network patients, by payer.

These can be found on the ProAct SyncCare™ System portal. If there is a rate change, the provider will be notified by email of the effective date, and the rates will be automatically updated or on the SyncCare™ system on the effective date. From that point forward, those rates will be reflected in all revenue cycle management transactions.

IX. Using the SyncCare™ System

Obtaining benefit, eligibility, and appeals information and processing claims, appeals, and payments[14]

Protocols are established by the Standards Committee and included as default settings in the four most active action tabs (eSuperBills, eScripts, eCost Estimator, and eAuthorization). Processing of outlier patients (required services incremental to the standard protocol) are also automatically processed on the ProAct SyncCare™ System. These procedures are addressed in the practice set-up training and in the SyncCare™ System Users Guide.

The SyncCare™ System is designed to automate the entire patient management process, including Revenue Management Cycle from eligibility through claims processing, including disputed or rejected claims appeals processing.

The SyncCare™ System is a technology enabled protocol driven patient management system that enables a coordinated and integrated approach to comprehensive OSA care.

The first step is patient screening, which is completed using a module of the SyncCare™ System to enter patient data for digital scoring. The patient interface can be a website or, in the office, using a tablet or character recognition device. Choice of the screening input tool will be determined during the practice setup and training.

Screening results are immediately posted to a provider portal (tablet or portal on an existing computer) for review with the patient. If the Assessment is positive, a decision can be made to proceed with the first step, a Home Sleep Test ("HST") administered by ProAct.

Utilizing the SyncCare™ portal, the provider will issue an eScript for the HST. ProAct will process pre-authorization, if required, and administer the HST, obtain a study interpretation and diagnosis, and post the results to the referring practice portal. The provider must complete the following:

1. Enter patient insurance information,
2. Obtain eligibility and procedure cost estimates (Cost Estimator Tab) for patient signoff,
3. Schedule the HST on the SyncCare™ HST Scheduling Tab,
4. Issue an eSuperBill for the consultation,
5. Collect the patient portion of the bill, and
6. Process a deposit on the HST device.

After the HST results are received, the provider will have a patient consultation, and based on the Certified Sleep Specialist recommended treatment, the provider will use the SyncCare™ System to complete the following::

1. Obtain eligibility and procedure cost estimates (Cost Estimator Tab) for patient signoff,
2. eScript the treatment,
3. Obtain a pre-authorization from ProAct (All requests for services must be entered and approved prior to the service being rendered. ProAct will not authorize requests retrospectively),
4. Collect the patient portion of the bill.

If the treatment is a PAP device, ProAct's DME division will manage the treatment, including ongoing compliance management.

If the treatment is an Oral Appliance, the patient will be directed to a network dentist using the SyncCare™ Referral Tab. If the provider is a network dentist, during the current or future visit, the dentist will:

1. Complete a MAD impression
2. Issue an eScript (including MAD order specifications) on the SyncCare™ System,
3. Mail the MAD impression kit to the Dental Lab,
4. Issue a eSuperBill using the SyncCare™ System, and
5. Schedule a fitting appointment.

ProAct will process the order and continually post the delivery ETA on the SyncCare™ portal, so that the fitting appointment can be adjusted if necessary.

Provider will fit the appliance, eScript and schedule the Pulse O_2 test (approximately two weeks), and complete the first titration after the Pulse O_2 results are received. The first titration is including in the MAD fee. During that visit, the provider will eScript and schedule the efficacy HST (60 days post fitting).

The Provider will schedule follow-up visits according to protocol, as needed to review the efficacy HST and make further titrations, if required. The provider is responsible for the long term management of the patient's Oral Appliance therapy. For these visits, separate eSuperBills will be issued on the SyncCare™ System.

The Dental Network portal helps you maintain communication with general or specialty providers referring to you as a solution for their OSA patients.

X. Provider Compensation

Health Network providers are compensated according to the Fee Schedule Calculations contained in the Health Network Dental Services Agreement and as displayed on the SyncCare™ System portal. Provider fees are based on a percentage of the amount of reimbursement received by the network, payable to the provider within 20 calendar days of receipt.

Periodically, payors will adjust reimbursement rates which will, in turn, affect the amount of compensation to the rendering provider. Within 10 calendar days of receipt of a notice of rate change from the payor, ProAct will post a bulletin on this page describing the change and the effect on the provider.

Appeals of rejected or denied claims processing are the responsibility of the ProAct Reimbursement Department; however it is the Network Provider's responsibility to participate in the appeals or resubmission process by promptly completing the documentation request displayed on the Rejected and Denied Claims Screen of the SyncCare™ portal.

XI. Provider Dispute Resolution Process[15]

A. Provider Violations and Dispute Resolution

In order to respect providers' rights while simultaneously protecting consumers, ProAct maintains a formal mechanism to address participating provider alleged violations and resolve participating provider disputes. This Dispute Resolution Process is available to any participating provider when ProAct takes an action that changes the network status. The Dispute Resolution Process is not available for certain types of issues, such as:

- Repeated non-performance of obligations without corrective action
- Revocation of medical licensure
- Violations of professional standards

- The commission of unlawful acts

These situations constitute Termination for Cause, as outlined in the Contract. The ProAct Dispute Resolution Process is congruous with the contract between ProAct and providers who deliver services. The formal Dispute Resolution Process is documented and reviewed at least annually by the Credentialing Committee. The Chief Dental Director and at least one licensed participating provider sits on the Credentialing Committee.[16]

B. Addressing Alleged Violations [17]

All participating provider alleged violations of ProAct's contractual requirements or the provider's competency or conduct are addressed. All reports of violations are investigated and actions are taken according to the findings and the appropriate disciplinary steps outlined in the contract. A corrective action process may or may not be implemented prior to a decision to terminate, based on the type of violation as determined by the Credentialing Committee.

C. Providers' Right to Dispute

All participating providers have the right to dispute provider status actions taken by ProAct,[18] and are informed of their right to this Dispute Resolution process upon being accepted into the provider network.[19] Providers must submit all Dispute requests in writing.[20] The Dispute request must include:

- The nature of the problem
- Previous attempts, if any, to resolve the issue, and
- Any other pertinent information.[21]

The provider may submit all information in writing, either by electronic mail, surface mail, or other source of written communication.

D. Dispute Resolution Process

Once ProAct receives this request they will conduct the appropriate review and investigation based on the nature of the dispute. For all disputes related to professional competency or conduct this will include a Peer Review Panel. ProAct will resolve all dispute requests within 20 business days and send a written resolution letter to the disputing provider.

If the suspected provider violation involves behavior that could pose a significant risk to the health, welfare, or safety of consumers, the provider may be immediately suspended pending the results of the investigation.[22] ProAct provides written notification to the provider of the suspension. In all cases of immediate suspension, ProAct expedites the investigation.[23] A

suspended participating provider will not receive funding to continue services or receive new referrals from ProAct.

XII. Maintenance of Confidentiality and Access to Records

All participating providers must maintain patient confidentiality and establish and maintain policies, procedures and controls to ensure that no confidential, sensitive, privileged or Protected Health Information (PHI) is used, disclosed in violation of any federal or state law or regulation, including the Health Insurance Portability and Accountability Act (HIPAA). All information and materials provided by ProAct to the Provider shall remain proprietary to ProAct, including contracts, reimbursement rates and methodology, operation manuals and any information regarding ProAct's business activities which are not otherwise available to the general public.

Provider shall not disclose any such information or materials or use them except as may be required to perform Provider's rights and responsibilities under their contract or as required by law. ProAct and its Participating Providers will provide the other party, upon request and at no cost to the requesting party, reasonable and timely access to Patient's medical records and Claims information as is necessary to enable the requesting party to carry out its responsibilities.

The parties shall make a Participant's records available to applicable state and federal authorities involved in assessing the quality of care or investigating Participant appeals or grievances as requested and/or required. Provider's will maintain patient medical records, information and Claims information as required by applicable state and federal laws and regulations or ten (10) years, whichever is longer.

XIII. Patient's Rights and Prohibition of Discrimination

All Participating Providers agree and establish policies and procedures to prohibit discrimination against any Patient on the basis of any Federal listing of protected classes. Participating Providers also agree to abide by the Patient Rights and Responsibilities as set forth by ProAct.

A patient has the right to:

Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.

- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.

- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.

A patient is responsible for:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the healthcare provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

Endnotes

[1] NM 1 (a)
[2] [NM 1 (b)]
[3] [NM 2 (c)]
[4] (NM 3)
[5] [NM 3 (a), (b), & (c)]
[6] [NM 3 (a), (b), & (c)]
[7] [NM 3 (a) & (b)]
[8] [NM 5 (b)]
[9] [NM 5 (a)]
[10] [NM 6 (c)]
[11] [NM 6 (a. i.)]
[12] [NM 6 (a. ii.)]
[13] (NM 6 a. iii.)
[14] (NM 6. Iv.)
[15] (M 14)
[16] [NM 14 (f)]
[17] [NM 13]
[18] [NM 14 (a)]
[19] [NM 14 (d)
[20] [NM 14(b)]
[21] [NM 14(c)]
[22] [NM 17 (a)]
[23] . [NM 17 (b)]