

PROVIDER MANUAL

We think health insurance should be affordable, transparent, and friendly. We built Decent to drive down the cost of healthcare by aligning incentives, reducing waste, and encourage our members to seek care when they need it. Our goal is Affordable Healthcare for All.

Thank you for being part of that journey.



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Overview

We're so glad to have you in our network! To help make working with Decent simple, we have created this Provider Manual with direction and guidance around the basic operational processes of providers and provider organizations.

Provider Training

All contracted providers and provider organizations are required to provide appropriate training for employees and applicable subcontractors within 90 days of hire and annually. [Provider Review Requirements](#)

Providers must give regulatory and accrediting bodies the right to audit, evaluate, and inspect books, contracts, medical records, patient care documentation, other records of contractors, subcontractors or related entities for services provided on behalf of Decent for the time period required by applicable law following the termination of the contract or the completion of an audit, whichever is later.

Provider Insurance Requirements

Throughout the term of the contract, providers must maintain a malpractice, general liability and any other insurance and bond in the amounts usual and customary for Covered Services provided with a licensed managed care company admitted to do business in the State and acceptable to Decent. Providers must immediately notify Decent of any material changes in insurance coverage or self-insurance arrangements and must provide a certificate of insurance coverage to Decent upon Decent's request. Copies of insurance policies and/or evidence of self-insurance must be provided to Decent upon request.

Compliance with the Americans with Disabilities Act (ADA)

Decent employees, business partners and contracted Provider Organizations must comply with ADA requirements, including compliance with Section 504 of the Rehabilitation Act which requires that electronic and information technology be accessible to Explanation of Benefits with disabilities and special needs.

Confidentiality and Protected Health Information (PHI)

Decent and its Provider Organizations are considered "Covered Entities" under the Privacy Rule, implemented pursuant to HIPAA, and must comply with the strictest applicable federal and state standards for the use and disclosure of PHI. Decent and its providers are required by federal and state laws to protect a member's PHI and are also required to report any breach in confidentiality immediately. Decent maintains physical, administrative, and technical security measures to

safeguard PHI; it is important that any delegated entities maintain these safeguards of PHI as well.

Please note that Decent does not offer routine dental or vision coverage.

1. Texas Access Standards

Decent is dedicated to providing access to high quality providers and strives to ensure strong network coverage for all Decent members' needs. Decent will work with members and providers to ensure members have access to appropriate, timely, and continued care.

Our provider access standards specify that our contracted providers meet the following time frames:

- Urgent care appointments for medical conditions: within 24 hours of the request for appointment
- Urgent care for behavioral health services: within 24 hours of the request for appointment
- Routine appointments for primary care: within seven calendar days of the request for appointment
- Routine appointments for medical conditions: within three weeks of the request for appointment
- Routine appointments for behavioral health conditions: within two weeks of the request for appointment
- After-hours care: Each primary care and specialist physician must have a reliable 24-hour-a-day, 7-day-a-week answering service or machine with a beeper or paging system.
- A recorded message or answering service that refers members to emergency rooms is not acceptable. The same standard applies to behavioral health practitioners who are physicians with hospital admitting privileges.

Texas gynecologist as principal physician

When a woman uses both a gynecologist and a PCP for her care, the physicians should work together to coordinate her care. They should use their standard processes to communicate the treatment plans, services rendered and summaries of visits.

2. Doing Business with Decent

Enabling ACH Payments

Organization admins with the should complete the [Electronic 835](#) and EFT request form to start receiving payments electronically via ACH.

Check Eligibility and Benefits

Call 866-432-7887.

Sample Member ID Card - Please note: actual member cost share will vary based on plan type.



Find In-Network Partners

Search for in-network providers, lab facilities, pharmacies, and hospitals on www.decent.com

Pharmacy

Costco manages our pharmacy benefits. For drug approvals, call 866-432-7887, or initiate one electronically.

Prior approval

To confirm which procedures require prior approval, Please review our Member Plan Document Prior approval sections. Request prior approval, or check the status of an existing approval, call 866-432-7887.

A list of services that require prior approval is also included in the Clinical Management section of this Manual.

Submit Claims

Claim Type	Network	Submit To
Medical	Decent	Electronic Payer ID: DECENT Address: P.O. Box 4366 Seattle, WA 98194
Pharmacy	Costco	Electronic Payer ID: CWHS

A Better Member Experience

Many of Decent's individual and family plans include great benefits like free primary care, mental health, OB/GYN visits, preventive care, and generic drugs.

Member's Rights and Responsibilities

Decent ensures the following rights and responsibilities for Decent members:

- A right to receive information about Decent, its services, its practitioners and providers and member rights and responsibilities. For more information please see our website at approval.Decent.com or call member services at 866-432-7887.
- A right to be treated with respect and recognition of their dignity and their right to privacy by all providers, practitioners, Decent contracted vendors and Decent staff.
- A right to participate with practitioners and providers in making decisions about their health care.
- A right to a candid discussion with their practitioners and providers of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice grievances or appeals about Decent and its contracted providers and practitioners regarding the care or services they provide. Grievances may be communicated by calling member services at 866-432-7887.
- A right to make recommendations regarding Decent's member rights and responsibilities policy.
- A responsibility to supply information (to the extent possible) that Decent and its practitioners and providers need in order to provide care.

- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

See [Member Plan document](#)

Members will be able to sign up for coverage anytime year round, however, due to administrative restrictions there will be a minimum of a 30 day lag. i.e. If a member calls April 5th for coverage, coverage begins June 1.

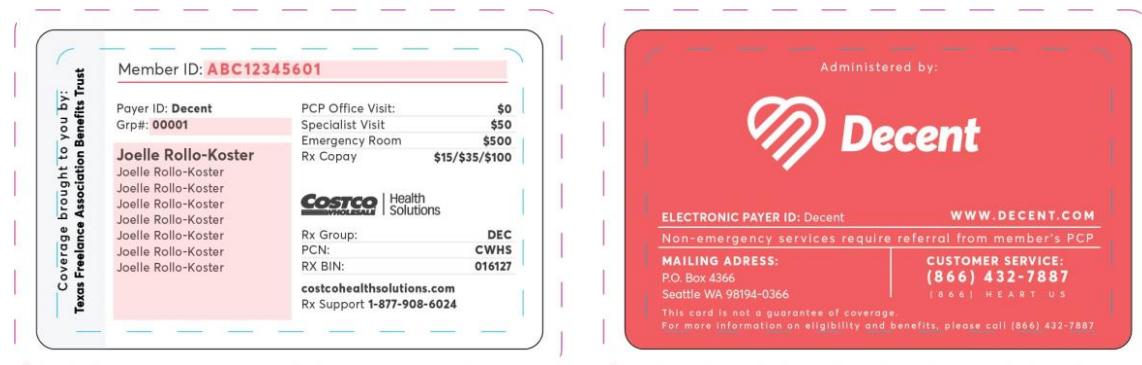
The exception to this is in the traditional open enrollment Nov. 1 - December 15th for coverage starting January 1. This is an Open Enrollment period where folks can renew or choose other coverage and waive the 30 day waiting period.

3. Verifying Eligibility

While providers are responsible for verifying member coverage and benefits prior to rendering any non-emergency services or treatments, we've made it easy for you to identify our members.

All Decent members receive and should present to you a Member Identification Card (ID) with the following information:

Name of the Member's plan
 Member ID #
 Member first and last name
 Contact information for Member Services



Decent will not pay claims for members not eligible at the date of service or for individuals not covered by Decent.

4. Claims

Providers may submit claims electronically or via mail. In-network providers will be reimbursed according to the rates established in their provider agreements. This section outlines Decent's claims policies and processes.

In the event that multiple contracted rates apply to a claim (including scenarios in which a provider is both directly contracted with Decent and part of a leased network or contracted provider organization), or that contracted rates exceed billed charges, Decent, in its sole discretion, may pay the claim at billed charges or in accordance with the agreement with the lesser reimbursement rate.

Claims Submission

Electronic Submission: Decent highly recommends that providers submit claims electronically using Decent's Electronic Payer ID: DECENT.

If you are having any issues setting up the ability to submit claims electronically, please contact your billing vendor/clearinghouse to ensure they have Decent's Payer ID in their system.

Paper Claim Submission If a claim cannot be submitted electronically, a paper UB-04 or CMS-1500 should be submitted to:

Decent
P.O. Box 4366
Seattle, WA 98194

Timely Filing of Claims

Providers should refer to their respective contracts for timely filing deadlines when submitting claims. Unless a different timely filing deadline is specified in the contract, the timely filing deadline for a provider to submit claims will be 90 days from the last date of service for a provider and 180 days from the last date of service for a hospital or ACO.

Late charges or bills to a previously submitted claim must be received within 180 days of the last date of service, or the timely filing deadline in the contract, whichever is earlier.

If a provider enters into a formal dispute resolution process with Decent, the provider should refer to the timeliness guidelines in the Dispute Resolution Section of this Manual.

Providers must claim benefits by sending Decent properly completed claim forms itemizing the services or supplies received and the charges.

Decent will not be liable for benefits if Decent does not receive completed claim forms within this time period.

Claim Forms

For all claims submitted via mail, Decent requires the CMS-1500 Form for professional services and the UB-04 Form for facility services.

The International Classification of Diseases (ICD-10) diagnosis codes and HCPCS/CPT procedure codes must be used. All field information is required unless otherwise noted.

Required for all institutional services claims. All field information is required unless otherwise noted.

If unlisted or miscellaneous codes are used, notes and/or a description of services rendered must accompany the claim. Using unlisted or miscellaneous codes will delay claims payment and should be avoided whenever possible.

Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

5. Claims Processing

Requests for Additional Information

During the claims adjudication process, Decent will sometimes ask a provider for additional information—such as medical records, acquisition invoices, or itemized bills. Decent will make any requests for more information within 30 calendar days of receiving the claim.

Providers are expected to submit the requested information to Decent, along with the original claim and a copy of the information request , within 60 working days of receipt of the request.

The requested document should be sent to:

Decent
P.O. Box 4366
Seattle, WA 98194

Once the required information is received, Decent will process the claim before the timely payment deadlines.

Timely Processing of Claims

Decent will process and pay all complete claims by the state-mandated timely payment deadlines. These deadlines are:

- 30 calendar days after the earliest date the undisputed claim is received for claims submitted electronically
- 45 calendar days after the earliest date the undisputed claim is received for claims submitted by mail

If a claim is pended with a request for additional information, the timely payment deadline will be calculated as the greater of 15 days or the net of 30/45 days (depending on submission method) minus the number of days taken to adjudicate the original claim.

Good Faith Payments

If Decent, in its sole discretion, determines that it has denied or reimbursed a claim correctly but agrees to overturn the denial or issue additional payment in the interest of the member, these "Good Faith Payments" will not be eligible for any interest or penalties related to late payment.

Incomplete Claims

Claims that are determined to be incomplete due to incorrect or missing required information (e.g. invalid CPT codes) will be denied. Providers will need to re-submit these claims with the appropriate information for the claims to be adjudicated.

Claim Denials

Decent will notify members in situations where a denied claim could lead to member financial responsibility. It will include the reason for denial as well as an explanation of appeal rights.

Interim Billing

Decent does not accept interim claims for inpatient services. Claims may only be billed upon patient discharge.

Claims for Emergency Services

Emergency services do not require prior approval. However, post-stabilization services require notification and may be subject to review and medical necessity determination.

Claims Overpayment

Should Decent determine that it has overpaid a claim, Decent will submit a refund request to the provider. This request will include the patient's name, date(s) of service, amount of overpayment, all interest and/or penalties associated with the overpayment, and an explanation of how Decent determined that an overpayment had been made.

Decent must make any refund requests within 180 calendar days of the date of payment of the affected claim. However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing.

Upon receiving this request, the provider must issue the refund or submit a clear, explanation of why the refund request is being contested within 45 calendar days of the date the notice of overpayment was received.

If the provider contests the refund request, the provider must identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

Providers should send refund checks or notices contesting refund requests to:

Decent Refunds
P.O. Box 4366
Seattle, WA 98194

Should the provider fail to issue the refund or notify Decent of a contested overpayment within 45 calendar days, the amount of the overpayment may be deducted from future claims payments until Decent has been fully reimbursed. An explanation will accompany all deductions made from future claims payments.

Balance Billing

Except for copayments and deductibles, providers must not invoice or balance bill Decent members for the difference between the provider's billed charges and the reimbursement paid by Decent.

If providers do not comply with rules laid out in their contracts, in this manual, or by state regulators, providers cannot hold members liable for payment.

Decent will comply with, and expects providers to be compliant with, State regulatory mediation process for eligible out-of-network claims.

This process is available to members with claims for medical services or supplies provided in in-network hospitals by the following types of out-of-network hospital-based physicians: (i) radiologists, (ii) anesthesiologists, (iii) pathologists, (iv) emergency department physicians, (v) neonatologists, and (vi) assistant surgeons.

To be eligible for mediation, the member must have been balance billed more than \$500 (not including copayments, deductibles, or coinsurance amounts). If Decent receives a mediation request from the State for a qualifying claim, Decent will notify the provider and arrange a teleconference call to resolve the dispute.

Decent will schedule the teleconference no later than 30 days after the date the member submitted the request to the State. Decent will notify the physician and member of the date and time of the call and supply a toll-free conference line number.

If Decent, the hospital-based physician, and member cannot settle the dispute during the teleconference, Decent will submit a request to the State for a formal mediation.

To avoid Out-of-Network mediation situations, Decent asks providers to make their best effort to refer members to in-network Decent providers and labs.

Further information about Texas mediation process can be found on the TDI website:
<http://approval.tdi.texas.gov/consumer/cpmmediation.html>

Until the mediation process has been exhausted, provider may not actively seek to collect from the member. This includes sending the member to collections for non-payment.

Reimbursement Policies

Decent reimburses in-network providers according to the policies listed in the [Reimbursement Policies](#) section of this site. Decent may modify its reimbursement policies at any time by publishing new versions to this site and providing advance notice to providers of expected changes in accordance with state law if applicable.

Collection of Cost Share

Covered services provided to Decent members may be subject to a deductible, a coinsurance amount, or a copayment amount. In these cases, the member will be liable for reimbursing the provider the relevant amount.

Decent encourages providers to collect copayments upfront. The provider is expected to collect the cost share as outlined in the member's benefits, never exceeding the full negotiated rate for the services rendered.

If a provider collects an upfront amount that exceeds the member's cost share, Decent requires the provider to issue a refund to the member within 10 working days of receipt of the EOB.

Copayment and coinsurance amounts for the most common services are indicated on a member's ID card.

Providers can also check a member's outstanding copayment amount, coinsurance amount, or deductible by calling Decent Member Services at 1-866-432-7887.

6. Clinical Quality

Decent promotes the delivery of high quality, medically necessary, cost-efficient care for members. The clinical program outlines policies and procedures by which Decent determines medical necessity, access, availability, appropriateness, and efficiency for clinical services and procedures based on a member's health benefits.

Decent's clinical program activities include pre-service (prior approval), concurrent, and post-service (retrospective) reviews.

It is important to note that neither prior approval nor notification is required for Emergent or Urgent Care.

Decent requires a member's primary care to issue a referral to specialists or to any other provider.

Payment for services is provided when a member's primary care has issued a referral and the requested service is a covered benefit, deemed medically necessary.

In order to minimize the potential for care delays, Decent recommends that prior approval requests be received within the following timeframes when feasible:

- At least five (5) days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility
- At least thirty (30) days prior to the initial evaluation for organ transplant services
- At least thirty (30) days prior to receiving clinical trial services
- At least five (5) days prior to a scheduled inpatient behavioral health or substance abuse treatment admission
- At least five (5) days prior to the start of home healthcare services

Clinical Criteria

Decent develops Clinical Criteria and protocols for the determination of Medical Necessity and appropriateness of healthcare procedures and services.

Decent is committed to the philosophy that evidence-based guidelines are known to be effective in improving health outcomes.

Decent's goal is to meet and exceed all the highest clinical and customer quality standards and reporting requirements.

Clinical Criteria are:

- Based on CMS nationally-recognized standards; developed in accordance with the current standards of national accreditation entities;
- Developed to ensure quality of care and access to needed healthcare services;
- Evidence-based; and
- Evaluated and updated at least annually.
- Reviewed and updated annually.

Lastly, Decent also evaluates the adoption of new medical technologies for medical/surgical procedures, behavioral health, pharmaceuticals, and medical devices to be used in the Clinical decision process.

Decent also considers the local network and delivery system available to members with specific needs, e.g. for services rendered by skilled nursing facilities, subacute facilities, and home health agencies.

Decent reviews an individual member's unique situation and works with the member's PCP to provide specific guidance tailored to the member and any special circumstance.

Decent maintains a list of medical procedures and services that require prior approval, which is shared on the Decent website.

The following factors are considered when building this list:

- Risk of fraud, waste, and abuse (including overuse and misuse)
- Availability of alternatives that may be a more appropriate first course of treatment
- Whether coverage of a given benefit is contingent on medical necessity

In the case of an adverse determination, the clinical criteria relevant to the review are summarized in letter the provider and member.

Decent captures and analyzes data, including but not limited to:

- Claims related Healthcare Effectiveness Data and Information Set (HEDIS) data to measure performance on areas of care and service
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to measure member satisfaction and the experience of care
- Internal data from Health Risk Assessments (HRAs)
- Practitioner performance and effectiveness of incentives
- Clinical management
- Preventive Health and Wellness Initiatives

Preventive Care Guidelines

- US Preventive Services Task Force: The Guide to Clinical Preventive Services includes U.S. Preventive Services Task Force (USPSTF) recommendations on screening, counseling, and preventive medication topics and includes clinical considerations for each topic. Includes guidelines for adults 20-64 and 65+ years as well as children 2-19 years. <https://approval.uspreventiveservicestaskforce.org/>

- Advisory Committee on Immunization Practices (ACIP): Medical and public health experts who develop recommendations on the use of vaccines in the civilian population of the United States. The recommendations stand as public health guidance for safe use of vaccines and related biological products. Includes guidelines for children under 24 months.
<https://approval.cdc.gov/vaccines/hcp/acip-recs/index.html>
- The American Congress of Obstetricians and Gynecologists (ACOG):
<http://approval.acog.org>
- American Academy of Pediatrics: Evidence-based decision-making tools for managing common pediatric conditions. Includes guidelines for children 2-19 years. <http://pediatrics.aappublications.org>

Acute/Chronic Medical Condition Guidelines

- American College of Cardiology: Framework of evidence-based clinical statements and guidelines developed by leaders in the field of cardiovascular medicine.
<http://approval.acc.org/guidelines>
- American Diabetes Association: Standards, guidelines and clinical practice recommendations for healthcare professionals who care for Explanation of Benefits with diabetes.
http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf
- National Guideline Clearinghouse: Publicly available database of evidence-based clinical practice guidelines and related documents. <http://approval.guideline.gov>
- American College of Physicians: American College of Physicians Resource for Clinical practice guidelines addressing screening, diagnosis and treatment of diseases relevant to internal medicine and its subspecialties. <https://approval.acponline.org/clinical-information/guidelines>

7. Prior Approval Requests and Notifications

To confirm requirements for a specific code or service, visit [Member Plan Document](#) or call 1-866-432-7887. Providers can use this same phone number to request approval and check the status of an existing approval.

Decent will not reverse an approval where the provider relied upon written or oral approval of Decent (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or fraud.

Decent requires approval for some services. It is important to submit any elective or pre-service requests in advance to ensure everything is in place for your patients to get the right care.

Please note that the list of services within each category might not be exhaustive. To confirm requirements for a specific code or service, call 1-866-432-7887.

For any other services not indicated in these resources, providers can call 866-432-7887.

- Transplants

- Ambulance – non-emergent air;
- Congenital Heart Disease surgeries;
- Durable Medical Equipment that will cost more than \$1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Genetic Testing – BRCA (breast cancer gene);
- Home health care;
- Hospice care - Inpatient;
- Hospital Inpatient Stay - all scheduled admissions. *Note:* For Hospital Inpatient Stays:
- The length of the Inpatient Stay must have Prior approval. The Provider may request additional days to be authorized, if needed; and
- the transfer to another Hospital or to or from a specialty unit in a Hospital requires another Prior approval;
- Outpatient Surgery
- Sleep studies;
- Mental Health Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Neurobiological Disorders - Autism Spectrum Disorder Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA);
- Orthognathic surgery performed on an Inpatient basis;
- Pregnancy services for an Inpatient Stay that exceeds the number of hours allowed as described in Section 6, *Details for Covered Health Services*;
- Private Duty Nursing;
- Prosthetic devices that will cost more than \$1,000 to purchase or rent;
- Reconstructive Procedures, including breast reduction surgery;
- Serious Mental Illness - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Sleep apnea surgeries;
- Therapeutic treatments – outpatient - all outpatient therapeutic treatments; and transplants.

Network Providers are responsible for obtaining Prior approval from Decent Inc. before providing services, however, there are some Network Benefits for which you are responsible for obtaining Prior approval from Decent Inc. Please call Decent Customer Service 1-866-432-7887 to verify benefits and obtain approval

Emergency, Urgent, and Ambulance Services

No prior approval is required for emergent or urgent services, including emergency ambulance. Post-stabilization care and services require notification and may be subject to review.

Members who reasonably believe they have an emergent medical condition that requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.

Emergency ambulance services are covered from the site of the medical emergency to the nearest appropriate facility or between facilities when a higher level of care is required to stabilize and treat an emergency medical condition.

Participating hospitals are responsible for notifying Decent of an emergent/urgent inpatient admission within 24 hours or by the end of the first business day following admission, unless otherwise specified in your contract.

Non-participating hospitals are required to notify Decent prior to any emergent/urgent inpatient admission when further care or treatment is needed following stabilization of an emergent/urgent condition. Failure to comply with

Decent's notification requirements will result in an administrative denial of the claim payment. Members cannot be held liable for claims denied for failure to notify. Notification may be communicated by phone 866-432-7887 to Decent.

Post-Stabilization

Decent requires prior approval as a prerequisite for payment for necessary inpatient medical care following stabilization of an emergency medical condition. Non-participating facilities are required to notify the plan once our member is stabilized and prior to any admission or post-stabilization care. If we do not respond within one hour, the initial post-stabilization service has been approved. Unless otherwise specified in their contracts, Decent participating facilities are required to notify the plan within 24 hours or by the end of the first business day following admission. The plan will review these requests for medical necessity, level of care, appropriateness of care, and benefit determination.

Experimental and Investigational Treatments

Decent reserves the right to deny benefits as experimental, investigational, or unproven for any service, treatment, therapy, procedure, device, or drug that is utilized in a manner contrary to standard medical practice or that has not been demonstrated through medical research to have a beneficial impact on health outcomes. If coverage is denied, an appeal may be submitted, including any pertinent medical records and/or supporting medical evidence. Decent is responsible for all decision-making related to experimental, investigational, and unproven services, and such requests will be reviewed.

Decent retains documented policies and procedures as specified by the Plan and as required by federal and state regulation. You may contact Decent with any questions about the plan and related documentation, including but not limited to:

Plan, policies, and procedures, including clinical criteria and guidelines

Clinical records including prior approvals and denials

Decent's clinical review decisions are based on medical necessity and benefit eligibility.

8. Appeals

Claim review requests must be submitted in writing on the form. There are two (2) levels of claim reviews available to you.

For the following circumstances, the 1st claim review must be requested within the corresponding timeframes outlined below:

Dispute Type	Timeframe For Request
Audited Payment	Within 30 days following the receipt of written notice of request for refund due to an audited payment
Overpayment	Within 45 days following the receipt of written notice of request for refund due to overpayment
Claim Dispute	Within 180 days following the check date/date of the Explanation of Benefits, for the claim in dispute

Decent will complete the 1st claim review within 45 days following the receipt of your request for a 1st claim review.

You will receive written notification of the claim review determination.

If the claim review determination is not satisfactory to you, you may request a 2nd claim review. The 2nd claim review must be requested within 15 days following your receipt of the 1st claim review determination.

- Decent will complete the 2nd claim review within 30 days following the receipt of your request for a 2nd claim review.
- You will receive written notification of the claim review determination.

The claim review process for a specific claim will be considered complete following your receipt of the 2nd claim review determination.

Mail the [completed](#) form, along with any attachments, to the appropriate address indicated on the form.

In cases where an approval request is denied, the enrollee or the enrollee's authorized representative will have an opportunity to appeal the decision.

Upon resolution of every appeal, a resolution is sent to the member, which, in the case of an adverse determination, will include an independent medical review application, an instruction sheet, and an addressed envelope. A copy of this will also be sent to the member's authorized representative, if applicable.

In Texas, members or their authorized representatives may request an Independent Medical Review of disputed healthcare services if they believe that healthcare services have been improperly denied, modified, or delayed by Decent or one of its contracting practitioners

Decent is dedicated to providing best-in-class experience and quality of healthcare for our members. Decent's vision is to build affordable healthcare for all. This will be accomplished by removing waste from the system, embracing transparency, and incentive realignment. We are focused on improving outcomes with innovative health programs, direct primary care, and minimize health disparities.

9. Potential Quality Issues

Definitions

- Potential Quality Issue (PQI): is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care issue exists.
- Quality of Care (QOC) Issue: is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.
- Quality of Service (QOS) Issue: is defined as a confirmed adverse variation that causes dissatisfaction and a poor experience in the delivery of healthcare services.
- Clinician or Provider: is any individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity, if licensure or certification is required by State law or regulation.

Process

It is our policy to accept a PQI referral through a variety of sources. These include but are not limited to: Internal referrals from Grievances and Appeals; a Plan member; a Plan provider; a Plan staff member; an affiliate.

All PQIs that are identified will be tracked in the PQI log for the purposes of monitoring patterns to identify any potential trends or any significant events. All information obtained during and used in a quality of care investigation will be held in strict confidence.

A designated medical professional reviews all referred PQIs to identify whether a true Quality of Care or Quality of Service issue exists. Based on the initial review, a provider may receive a request for follow-up and evidence from the provider in question to demonstrate that the corrective actions have been implemented as specified.

Any identifiable trends, regardless of outcome to the member, will be reviewed for potential action or educational opportunities.

Reporting

To report a PQI, you may complete the PQI [Referral Form](#) on our website

10. Prescription Benefits Overview

Decent contracts with Costco to provide and coordinate the outpatient prescription drug benefit.

Costco, on behalf of Decent, is responsible for managing the pharmacy network, formulary, and all aspects of the outpatient prescription drug benefit, including any related medication management programs, approvals, denials and appeals. Costco adjudicates prescription claims at the point of sale.

Drug Formulary

The Decent formulary is a dynamic document updated two times a year by Costco Pharmacists. Medications on Decent's formulary generally remain consistent throughout any coverage year, but new medications and generics that become available are evaluated by Decent and individual medications may be added to or removed from the formulary.

To access the drug formulary go to www.decent.com/provider

To initiate a drug approval, use this [form](#).

11. Provider Network Access

Decent offers plans that require a member to designate a specific PCP. Members need a referral to see a specialist. The list of in-network providers and facilities by state can be found on the Decent website.

Members have limited out-of-network benefits (except in an emergency), please see [Trailblazer Member Document](#)

To create a streamlined experience, the following may be grounds for a provider's termination from Decent's network:

- Admitting members to out-of-network hospitals
- Performing procedures at out-of-network facilities
- Referrals to out-of-network providers (including laboratories)
- Availability Standards

Decent maintains a provider network and monitors the adequacy of the network to ensure provision of quality care and services to its members. The number, type and distribution of practitioners, pharmacies, and ancillary services are monitored on an ongoing basis to ensure the network is sufficient to meet the needs of members.

Authorizing an Out-of-Network Provider

If it is determined that Decent does not have an in-network provider with the appropriate training and experience needed to treat a member's condition, Decent will approve an out-of-network utilization. Requests for out-of-network approvals may be made by the member or the member's primary care physician.

Please note: approvals will not be made on the basis of convenience for either a member or a provider, and Decent may not approve the particular out-of-network provider requested.

If Decent approves, all services performed by the out-of-network provider are subject to a treatment plan approved by the member's primary care physician in consultation with the member.

All services rendered by the out-of-network provider will be paid as if they were provided by an in-network provider, and members are responsible for any applicable in-network cost-sharing.

In the event that Decent does not approve, any services rendered by the out-of-network provider will not be covered.

Transitional Care

Decent understands that when providers leave the network or are terminated from the plan, members may require coverage for a period of time to ensure continuity of treatment.

As such, members who are being treated by a provider whose contracted status has been terminated may be able to continue ongoing treatment for covered services for up to 90 days after the effective date of termination.

In addition, pregnant members in their second or third trimester may be able to continue care with a former in-network provider through delivery and any postpartum care directly related to the delivery.

Please note: members must contact Member Services to request this continuity of care and it must be authorized prior to service.

Formerly in-network providers must agree to accept as payment the negotiated fee that was in effect just prior to the termination.

If a provider was terminated by Decent due to fraud, imminent harm to patients, or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with that provider is not available.

This document is a guide for how to work with us. If you ever have questions, please don't hesitate to reach out to us.



We look forward to working together! Questions? We're here to help.

Phone

1-866-Heart-Us

Customer Service Hours of Operation: Mon-Fri, 8am-6pm

support@decent.com