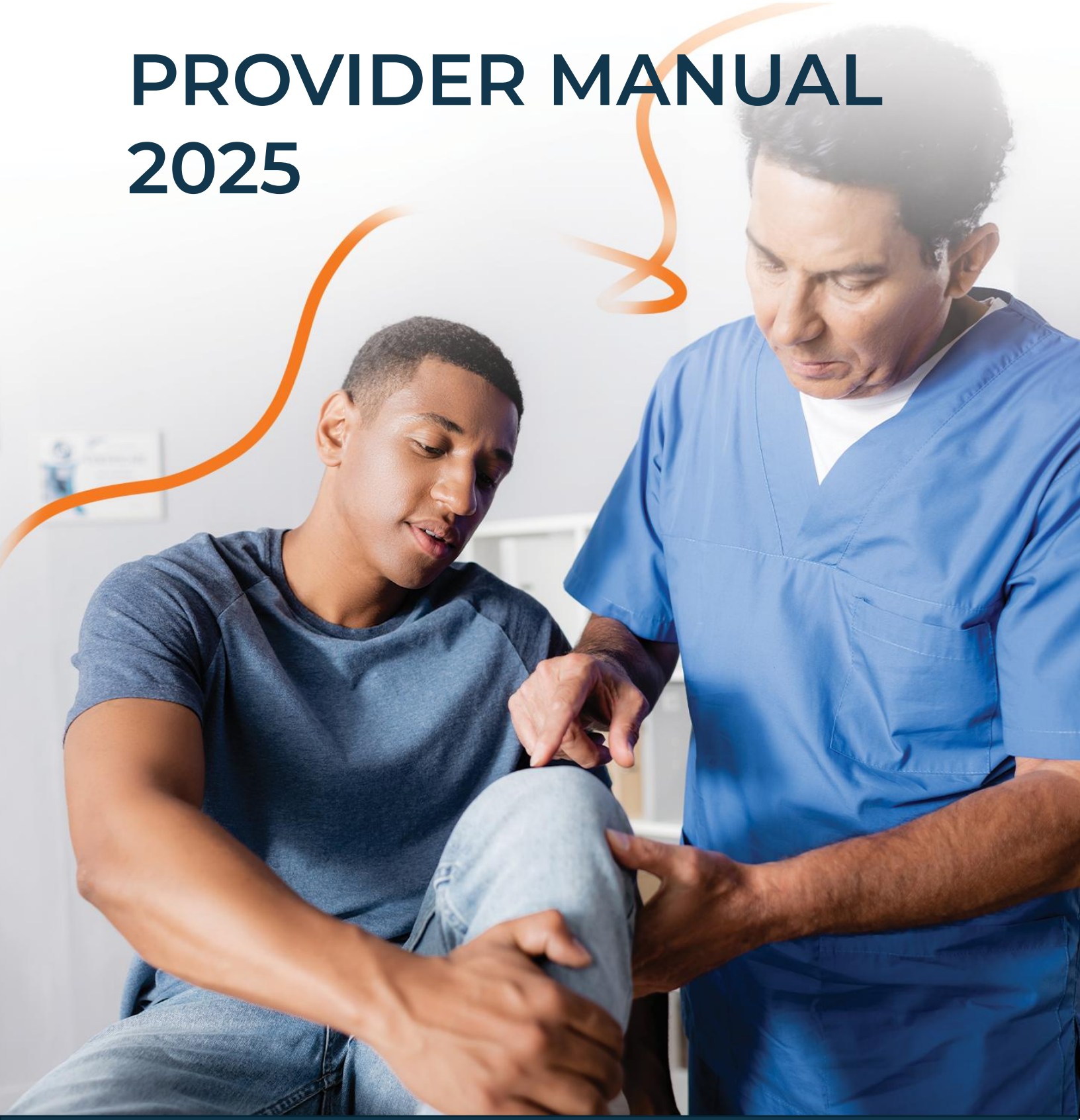
SimpleTherapy
SimpleMSK

PROVIDER MANUAL 2025



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Introduction

Welcome to SimpleTherapy's network of providers. We view the outpatient physical medicine services we provide as an integral component in the overall health and well-being of each of our Members and strive to work with the highest quality health service providers to achieve this.

Purpose of Manual

This provider manual was developed to be a resource for the requirements, policies, and procedures that apply to our Participating Providers. It will also familiarize you with our philosophies and expectations.

Rebrand Journey

In 2022, SimpleTherapy, Halcyon Behavioral, and PhysMetrics—each with a strong legacy of innovation—joined forces to create a unified brand focused on complete care: from musculoskeletal support to behavioral and physical health.

Under the umbrella of SimpleTherapy, PhysMetrics was renamed to SimpleMSK, which provides expert hands-on care and virtual physical therapy to support members' movement, health, and well-being.

Our Services

SimpleTherapy offers a wide array of innovative services to our clients:

- **Employee Assistance Programs:** We offer solution-focused employee assistance and work-life programs through SimpleEAP. We help our Members confidently manage personal problems that may affect job performance, while helping employers address employee emotional issues before they manifest into disruptions in the workplace.
- **Health & Wellness Programs:** Our wellness programs through SimpleWellbeing help clients get healthier through health assessments, targeted intervention, proactive health coaching and engaging wellness-related competitions and challenges.
- **Behavioral Health Programs:** We provide complete mental health and substance use disorders (MHSUD) benefits to self-insured organizations through SimpleBehavioral. Through a confidential and comprehensive telephonic assessment, each member's needs are immediately triaged

and referrals to medically appropriate care are provided either in person or virtual.

About SimpleMSK

SimpleMSK is licensed as a third-party administrator, headquartered in Central California. We are a streamlined physical medicine benefits management company with an emphasis on customer service, flexibility, and accountability to our Members. For more than 20 years, our team has partnered with self-insured organizations to provide high-quality, cost-effective chiropractic and complementary medical care throughout the United States.

We tailor each plan individually to our Members unique needs. Every aspect of a program's performance is regularly reported and reviewed with Members. We are committed to providing evidence-based, effective treatment to our Members that is individualized for their specific physical medicine needs and conditions. We are proud to facilitate this care for thousands of people every day.

Mission

SimpleMSK is a full-service complementary health management company committed to customer service, accountability to our clients, and effective management of complementary health benefit programs.

Provider Resource Guide

Refer to the resource guide below to quickly find the information you need.

Resource	Contact Information
Customer Service (eligibility, claims, etc.)	Use the contact information to reach us: Phone: 877-519-8839 Email: msk.support@simpletherapy.com Send Physical Medicine claims to: SimpleMSK P.O. Box 25220 Fresno, CA 93729-5220 You can also submit claims through Office Ally using Payor ID PM001. **Note:** All emails containing PHI need to be sent via secure methods.
Clinical Services (prior authorization, medical necessity review, etc.)	Use the contact information to reach us: Fax: 888-439-4819 Email: msk.clinical@simpletherapy.com **Note:** All emails containing PHI need to be sent via secure methods.
Online Provider Access 24/7/365 (verify eligibility, claim and auth status, etc.)	Use the link below to access the provider portal: https://oai.quickcap.net/oai/
Provider Relations (contracting, credentialing, networks, etc.)	Phone: 559-400-6245 Send an email to: provider.relations@simpletherapy.com **Note:** All emails containing PHI need to be sent via secure methods.

Participating Providers

Participating Providers are independent contractors of SimpleMSK. This means that you practice and operate independently and are not employees of SimpleMSK. Network participation is determined by meeting the credentialing standards identified later in this document, and we do not discriminate based on race, creed, color, national origin, religion, gender, sexual orientation, marital status, age, physical disability, or any other legally protected status. Additionally, participation status is not impacted if a provider files a complaint or an appeal with or against SimpleMSK.

Participating Providers are expected to provide our Member's with medically necessary, evidenced-based services and comply with the Participating Provider Agreement, Business Associates Agreement (BAA), as well as the policies and procedures outlined in this manual. This includes cooperation and participation in credentialing/recredentialing, contracting, care management, quality improvement, peer review, claims submission, and appeal and grievance procedures.

SimpleMSK utilizes each provider's unique 10-digit National Practitioner Identifier (NPI) number to access provider records such as claims, referrals, and authorizations. Our Provider Relations team can direct providers on how to apply for an NPI number, as needed.

Our team is available to assist with questions related to policies and procedures, member coverage, care and quality management activities, as needed. We support providers communicating with Members to discuss clinically appropriate, evidenced-based treatment options, regardless of benefit coverage determinations. Questions related to benefit plan coverage limitations should be directed to SimpleMSK member services representatives.

Participating Provider Responsibilities

SimpleMSK expects its Participating Providers to do the following:

- Provide services only as Medically Necessary in accordance with generally accepted medical, surgical, and scientific practices and community standards.
- Provide and coordinate continuity of care in the Member's best interest.
- Maintain quality standards for all health care services.
- Provide all services in a culturally competent manner.
- Ensure that offices are physically accessible to patients with disabilities, and have adequate parking, restroom facilities, seating, and a well-lit waiting area.
- Ensure office areas where care is provided are kept clean and orderly at all times.
- Maintain open physician-patient communication regarding appropriate treatment alternatives or when recommending a procedure. The physician recommendation does not guarantee coverage, as the service may require prior authorization.
- Effectively communicate with Members regarding their health care needs.
- Encourage Members to be active in decisions about their own treatment.
- As appropriate, notify Members when telehealth services are available, how to schedule a telehealth visit and whether there is any cost-sharing associated with a telehealth visit.
- Maintain licensures and other applicable credentials as required by law and SimpleMSK's policy.
- Verify each Member's eligibility prior to rendering services, unless it is an emergency. You can verify eligibility by logging into our system or calling us at 877-519-8839.
- Cooperate with SimpleMSK's Medical Director or designee in the review and supervision of the quality of care administered to Members.
- Respond within the designated amount of time to all requests for information related to potential quality of care issues and/or peer reviews.
- Maintain and preserve all records, including but not limited to medical and billing records, as required by law and medical standards.
- Provide medical histories, financial, administrative, and other records of SimpleMSK Member's as requested by SimpleMSK or SimpleMSK's designee.

- Actively participate in SimpleMSK's quality and utilization management initiatives.
- Treat all Members with respect and provide health care services without discriminating based on health status, race, religion, color, national origin, gender, age, disability, marital status, sexual orientation, and source of payment or any other unlawful category.
- Notify SimpleMSK within five business days of any change in practice, including but not limited to, a change of group affiliation, name, address, telephone number, type of practice, willingness to accept new Members, and/or languages spoken.
- Respond within 30 business days to SimpleMSK's annual or bi-annual request for affirmative updates to your information, or risk deletion from the Provider Directory.
- Comply with this Provider Manual, the terms of your Participating Provider Agreement, and state/federal laws.

Provider Responsibilities for Cultural and Linguistic Services

Providers are responsible for ensuring that Members fully understand their diagnosis and treatment guidelines, regardless of their preferred language. So that Members receive appropriate access to covered services, Participating Providers are expected to comply with federal and state requirements regarding cultural and linguistic services. This includes, but is not limited to, the following examples:

- Determine the Member's preferred language needs have been documented in their records, prior to meeting with the Member.
- Document Member's language requirements in medical charts.
- Inform Members of their right to interpreter services, at no cost to the Member, even when a Member is accompanied by a family member or friend who can provide interpretation services. Document all requests and refusals in the Members' charts.
    - Members should never be required to bring their own interpreter. The Member's family Members should not be encouraged to serve as interpreters, and minors should not be used as interpreters.
- Arrange for interpreting services at the time appointments are made.
- Post signs in appropriate languages informing Members about the availability of free interpreter services.

- Inform Members that they may call SimpleMSK to request translated documents at no cost and to register their preferred languages with SimpleMSK.
- Provide periodic training to office staff on cultural competency and use of interpreters.
- Call member services if you need assistance providing language assistance services (interpretation, translated documents, etc.) for Members.

For additional information or resources, email Provider Relations at provider.relations@simpletherapy.com.

Note: All emails containing PHI need to be sent via secure methods.

Credentialing and Recredentialing

To ensure Members have access to high-quality care, SimpleMSK requires all Participating Providers to meet and maintain credentialing standards consistent with National Committee for Quality Assurance (NCQA) guidelines.

Providers must submit complete and accurate credentialing applications, including demographic information, via simpletherapy.com/en/providers. Credentialing verification is conducted by Gemini Diversified Services using data from the Council for Affordable Quality Healthcare (CAQH). Providers are responsible for maintaining an up-to-date CAQH profile.

Credentialing includes primary source verification of licensure, education, training, malpractice coverage, sanctions, work history, and other relevant criteria. ADA compliance is also reviewed. Credentialing decisions are not influenced by race, ethnicity, gender, age, religion, sexual orientation, or patient mix. While demographic data may be requested, responses are optional and do not impact decisions.

Providers have the right to review information submitted during the credentialing and recredentialing process and to correct inaccuracies. Requests for corrections and status updates may be submitted at any time.

Initial credentialing reviews are completed within 30 days of receiving a complete application, with formal decisions made at quarterly Credentialing Committee meetings. Recredentialing occurs at least every 36 months to ensure continued compliance with regulatory and quality standards.

Providers will be notified of missing information and may review or correct submitted data upon request. Failure to complete recredentialing may result in termination of network participation.

Contracting

Once credentialing has been successfully completed, you will be sent a Participating Provider Agreement and Business Associates Agreement (BAA) for review, and execution to finalize your network status. These agreements include specific expectations of you, the Participating Provider, and of SimpleMSK. Included with this agreement is addenda and exhibits applicable to your provider agreement identifying our clients, services covered, and reimbursement schedules.

Our Participating Provider Agreement and BAA ensure that Members, providers and SimpleMSK have a clear understanding of the responsibilities and expectation of each of the parties. Please read those documents thoroughly to ensure you understand the terms included. This includes, but is not limited to:

- Accepting reimbursement provisions for covered services, which includes not "balance billing" Members for covered services other than for costs identified as member responsibilities (i.e., copayment, coinsurance, deductible) in plan documents.
- Following the notification period and adhering to the responsibility of notifying transitioning Members, in the event of network termination.

Sub-Contracting

SimpleMSK does not allow for sub-contracting in our Participating Provider Agreement. This means our Members must receive services from the individual approved through our credentialing process and named on the Participating Provider Agreement. SimpleMSK does not reimburse services provided by interns, practicum students, or any other non-licensed professionals to render services to SimpleMSK Members.

Changes to Contract Status

Our goal is to provide SimpleMSK Members and clients access to a diverse, highly qualified network of physical therapists. There are occasions where network status may be limited or terminated to ensure quality of care. Maintaining any and all professional licensure/certification, completing re-credentialing, utilization/quality management requests in specified timeframe, and complying with contractual and/or policy guidelines can prevent unwanted changes to your contract status.

Note: We do not consider advocacy for patient care, filing a complaint or submitting an appeal as reasons for network status changes.

If there are any actions that impact network participation status, you have the right to submit a written appeal of the decision. These decisions typically arise from quality-of-care issues based on deficits/abilities, to practice changes prompting change in network status as noted in Participating Provider Agreement subject to applicable federal/state law. This can include, but is not limited to:

- Identification of licensure sanctions and/or disciplinary actions
- Failure to complete re-credentialing process and/or meet required documentation/attestations requirements
- Quality of care review decisions

If this occurs, you will receive written notification that outlines the reason(s) for status change and summary of the appeal process. To appeal the network status change, follow the appeal instructions provided in the notification letter. SimpleMSK will consider each appeal submitted.

Contract Termination

Termination from the SimpleMSK provider network from specific or all product lines can occur for a variety of reasons, including those identified in changes to network status section. To terminate your participation in the SimpleMSK Provider Network, you must submit a written notice requesting to terminate your network participation and follow the terms identified in your Participating Provider Agreement. This includes facilitating the transition of our member(s) in your care to a SimpleMSK network provider able to meet their access and clinical needs. We will provide a written notification of your termination from our network, including the termination effective date. When your participation is terminated for any reason, it is your responsibility to inform all of your patients who may be affected with at least 30-days' notice.

Provider Information

To ensure our Members have access to current and accurate provider practice information, our Provider Relations Team routinely updates our credentialing database. In order to provide accurate information, we request timely notification within ten business days of any changes or updates to your practice that will impact our Members access to care. Notification must be submitted in writing and is required for the following information:

- Practice name or ownership
- Contact information (phone, fax, or email)
- Address (physical, mailing, or billing)
  - Includes a new or additional office location
  - Includes a new or modified billing or mailing address
- Hours of operation
- Non-English languages spoken by provider and in-office staff
- Tax Identification Number (TIN)
- Changes in clinical specialties, including documentation for education and or training needed to support specialized services can be provided
- Termination from practice, and/or joins another clinic or medical group, including employment by a federally qualified health center (FQHC) or primary care clinic.
- Any changes to information used in credentialing and re-credentialing activities, such as:
  - Licensure/certification, including actions by applicable governing agencies
  - Malpractice Insurance Coverage, including information about any actions pending or settled

We also request timely notification for any changes in practice operations, including, but not limited to the following:

- Leave of absences, such as maternity/paternity leave, illness, extended vacation, military assignment, etc.
- New practice ownership
- Practice closure

- Changes from group to independent practice or joining a group when previously in independent practice.

Any changes must be submitted in writing to our Provider Relations Department through one of the following:

- Submission of documents through the secure portal on our website.
- Fax: 877-519-8839
- Mail: P.O. Box 25220 Fresno, CA 93729-5220
- Email: provider.relations@simpletherapy.com

Note: Changes to a TIN require the submission of an updated W-9. This document can be provided upon request, or you can use your own.

Note: All emails containing PHI need to be sent via secure methods. Not reporting changes to SimpleMSK in a timely manner may impact network status, claims, and payment delays. We will contact you, or your identified practice representative, if any clarification or additional information is needed.

Care Management

SimpleMSK's care management program consists of a variety of utilization and quality management initiatives that provide clinical direction and oversight of benefit utilization. Our goal is to provide Members with effective and appropriate treatment through the benefits we administer to optimize positive treatment outcomes.

Accessing Services

As a network provider, we expect your compliance with benefit referral/certification requirements as well as timely responses to requests for appointment availability and new patient referrals.

Members can self-refer to any participating provider. Some services may require physician orders/referrals prior to the start of treatment.

Referral information will be provided in writing or by phone and include service(s) approved, length or approval period, and number of sessions/days approved.

Alternative plans of treatment are provided when needs are not covered by benefits administered by SimpleMSK or do not meet medical necessity criteria.

Most services require precertification after a pre-determined number of visits/sessions have been completed. This may differ based on a number of factors, including, but not limited to:

- The physical medicine specialty
- Types of services being provided
- Services covered by the member's benefit

Throughout the course of treatment, our staff is available to assist with identifying and securing referrals for additional and/or alternate services when needed.

Concurrent Review

During treatment, we require timely submission of treatment reports to ensure adherence to medical necessity guidelines and compliance with

member's specific benefit plan requirements. This includes, but is not limited to:

- Pre-treatment and concurrent review
- Chronic/complex cases
- Treatment that extends beyond the standard of care based on primary clinical issue(s)
- Other covered services

Our utilization and quality management process typically involves the review of clinical/medical record(s) and/or telephonic case consultations provided by a member of our review team with the applicable clinical expertise. Clinical Guidelines are used to determine if the treatment being provided is evidence-based and clinically appropriate.

We recommend providers maintain complete and current treatment records to facilitate this process. Concurrent review decisions are based on the documentation and information submitted by the provider. For the review of outpatient services, we require you submit the appropriate, completed report forms. Depending on the type of treatment being provided, submissions may require the following information:

- Patient information
- Diagnostic information
- History of condition
- Assessment
- Treatment history
- Current symptom(s)
- Subjective complaints
- Objective findings
- Functional outcome testing
- Current functional impairments
- Short- and Long-term goals
- Medication
- Radiology/imaging
- Coordination of care/multidisciplinary referrals

- Identification of patient's participation
- Identification of treatment progress and or response to treatment
- Plan of care
- Treating provider's signature

Note: The use/submission of objective data from standardized assessment tools is recommended to demonstrate treatment efficacy over the course of care and may be required for some types of treatment.
Medical necessity determinations are communicated to providers either in writing (email, mail, fax) and/or by phone. Depending on the plan requirements, determinations may not be provided by phone.

Determinations or decisions include the type(s) of service approved, length of approval period, and number of sessions/days approved. Any service denial will be provided in writing as legally mandated and include procedures for appealing adverse benefit decisions.

Quality of Care

Our expectation is that all professionals/facilities treat our Members with dignity and respect while providing safe, effective, patient-focused, treatment that meets professional standards of care, which includes maintaining complete and secure clinical records. Additionally, office and/or facilities should be safe and well maintained. Services provided through telehealth should be available on platforms compliant with professional, state and/or federal regulations. Members should not experience wait times exceeding 30 minutes for a scheduled appointment.

As needed, records beyond those identified above may be requested in the event of concurrent treatment and/or potential quality of care issues if documentation submitted does not adequately address these concerns. This can range from Members clearly notified of practice policies (e.g., consent for treatment, confidentiality, emergency procedures, etc.), to specialized physical medicine evaluation and testing.

Beyond maintaining complete and current clinical records, network providers are also expected to maintain 24 hours per day, 7 days per week telephone access. This includes procedures for triaging or screening Member telephone calls, which, at a minimum, shall include the use, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller:

- The length of wait for a return call from the provider; and
- How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

Through our care management program, we work to identify any issues in the provision of care and provide solutions to resolve quality of care concerns. Participating Providers are expected to join in any investigation of member complaints and adverse incidents. If an issue is identified, we will notify the provider in writing and make recommendations for corrective actions, as available. This may include additional provider training or incorporation of office management process, such as secure record storage, to address the specific quality of care issue identified.

Our team can also be available to provide clinical consultations or assist in coordination of services that promote member health and wellness while maximizing independence and access to available resources when requested. Through this process, we will also identify any benefit limitations and/or exclusions to treatment being provided and notify you in a timely manner.

Treatment Records and Site Review

In support of our care management program, we may conduct treatment records, review and/or site visits to assess the quality of care and services being provided to our Members. Participating Providers are expected to comply with requests to complete these activities. You will be provided with additional instruction if you are identified to participate in either review. This section contains general expectations for each type of review:

Records Review

Participating Providers are expected to maintain current, complete, and legible treatment records that include:

- Patient demographic information, including: phone number, address, emergency contact, and guardian information, as applicable.
- Patient identification on each document in their records, which are organized and stored securely (e.g., only authorized personnel have access).
- Signed copies of informed consent, patient bill or rights, release(s) of information for all involved parties. If a document is not signed, refusal must be documented.
- Presenting concerns.
- Diagnosis (ICD-10) and documentation to support diagnosis and/or physicians orders, including condition diagnosed.
- Assessment, including complete history of condition, identification of co-occurring disorders, risk assessment, medical history, including any allergies and current medication(s), identification of patient's strengths, abilities, motivations, and preliminary discharge plans.
    - **Note:** If treating a child/adolescent, include developmental history in the assessment.
- Functional outcome measures.
- Any additional testing indicated by condition being treated.
- Individualized treatment plan, including measurable goals aligned with areas identified for improvement, timeframes for achievement, evidenced based interventions, referrals to multidisciplinary and/or community resources, as applicable.
- Treatment plan modifications as needed to address barriers/lack of progress.

- Treatment reports/notes corresponding with each date of service that includes information to support plan of care, evaluation of assessment information (treatment progress and compliance), treatment goals, patient participation, and discharge plan.
- Coordination of care with primary care physician and other health providers as applicable and authorized by release of information.

Note: All entries listed above must be dated and signed by the treating provider.

Site Visits

Participating Providers are expected to adequately maintain physical office and practice accessibility standards as follows:

- Physical site appearance, space in waiting and treatment room, accessibility for handicapped Members, and access to restroom facilities.
- Training in office procedures and confidentiality for all staff.
- Availability/notice of after-hours care for emergencies.
- Phone message, which includes directions for emergency situations.
- Routine appointment availability and scheduling procedures.
- Records kept in secure location only accessible by authorized personnel.
- Documentation available on-site to verify licenses of clinical and/or any direct care staff.
- For telehealth services, approved/secure platform/space utilized for service delivery.

For both treatment records review and/or site visits, you will be notified in writing in advance if either review is required. Any information needed for the review should be prepared in a timely manner, and providers should be available to address any questions that arise from the review. If needed, providers are expected to participate in developing and implementing a corrective action plan.

Claims Submission

SimpleMSK strives to provide reimbursement in a timely manner, in accordance with the fee schedule included with your Participating Provider Agreement. To achieve this, we rely on accurate and complete claims submissions within contractually agreed upon filing guidelines.

Prior to submitting a claim, it is your responsibility to verify eligibility and prior authorization requirements. Please note, Members must be eligible on the date service(s) is rendered.

All information submitted on a claim must accurately reflect the services rendered including, but not limited to, any applicable time and/or service requirements. Services provided through telehealth will be reimbursed the same as when rendered in-person and should include the applicable telehealth modifier and/or place of service designation.

The following information is intended to provide clear requirements for claims submission:

- Submit claims within the timeframe identified in your Participating Provider Agreement:
  - 90 days from the date of service for in-network claims.
  - For secondary claims, 90 days from the date on the primary explanation of benefits.
- Submission Options – Claims may be submitted electronically through our clearinghouse partner or through the Plan's web-based claims submission process in compliance with HIPAA requirements.
- Electronic Claims Submissions (EDI Claims)
  - Providers can submit claims directly through Office Ally (Payer ID: PM001) or indirectly through their clearinghouse partnerships. Contact your billing system to determine what is needed to enable this transmission.
  - Providers can submit to us directly through web-based access into our system. To do so, you must establish a unique username/password to initiate the process for web-based claims submission. Visit https://oai.quickcap.net/oai/ to get started.
- Providers should regularly monitor claims submitted electronically and correct rejected claims, as needed.
- Paper claims include claims submitted by mail, fax, or secure email. They must be submitted on either a current CMS-1500 (for professional claims)

or UB-04 form (for inpatient and/or facility-based program claims). These submissions are scanned, and the data analyzed for automated upload into our system.

- Claims submitted must be complete, legible, and accurate.
- Additional notes and/or information that is illegible (i.e., too light for scanning to read, data not aligned with claim form, etc.) may not load into our system and will be returned.

- Submit clean claims for services rendered, including your usual charge amount.

Clean claims include the following:

CMS-1500 – Professional Claims	**UB-04 – Inpatient/Facility-based program Claims**
▪ Patient's/Subscriber's ID number ▪ Patient's name ▪ Patient's date of birth ▪ Patient's gender ▪ Subscriber's name ▪ Patient's address ▪ Patient's relationship to Subscriber ▪ Subscriber's address ▪ Identification, if patient's condition is related to employment, motor vehicle accident, or other accident ▪ Plan name ▪ Patient's or authorized person's signature or notation that the signature is on file with the provider ▪ Subscriber's or authorized person's signature or notation that the signature is on file with the provider ▪ Date of current illness or injury ▪ Name of referring provider, if applicable ▪ Referring providers NPI, if applicable ▪ Diagnosis code(s), current ICD-10 ▪ Date(s) or service	▪ Provider's name, address, and phone number ▪ Patient control number ▪ Type of bill code ▪ Provider's federal TIN ▪ Statement period ▪ Patient's name ▪ Patient's address ▪ Patient's date of birth ▪ Patient's gender ▪ Date of admission ▪ Admission hour ▪ Type of admission ▪ Source of admission ▪ Discharge hour, if applicable ▪ Patient discharge status ▪ Value codes and amounts ▪ Revenue code(s) ▪ Revenue/service description ▪ Service date(s) that include each date of facility-based non-impatient services ▪ Units of service ▪ Total charge ▪ Plan name ▪ Prior payments, if applicable ▪ Balance due, if applicable ▪ Main NPI number ▪ Subscriber's name

CMS-1500 – Professional Claims	UB-04 – Inpatient/Facility-based program Claims
▪ Place of service ▪ Procedure code(s), current CPT or HCPCS ▪ Modifier code(s), if applicable – current CPT or HCPCS ▪ Diagnosis pointer by specific service ▪ Authorization number, if applicable ▪ Charge(s) for each procedure ▪ Number of days/units ▪ Rendering provider's NPI ▪ Provider's federal TIN ▪ Identification if provider accepts assignment, if applicable ▪ Total charge ▪ Amount paid, if applicable ▪ Balance due, if applicable ▪ Pay to name, if different than billing provider ▪ Signature of provider that rendered service(s), including professional licensure or notation that signature is on file with the plan ▪ Name and address of where services were rendered ▪ Service facility NPI ▪ Provider's billing name and address ▪ Main NPI	▪ Patient's relationship to subscriber ▪ Subscriber's ID number ▪ Authorization number, if applicable) ▪ Diagnosis qualifier ▪ Primary diagnosis code(s), ICD-10 ▪ Admit diagnosis ▪ Provider name and identifiers

Remember to collect applicable copayments or coinsurance from Members. You may be required to submit information, in addition to the standard forms identified above, including, but not limited to, treatment records for review.

Secondary Insurance

For patients with other coverage, their specific Plan's Coordination of Benefits (COB) guidelines will be used. If a patient has additional coverage, this should be clearly identified, and all applicable information on the other health

benefit plan should be completed. Contact our staff and/or refer to member's plan documents for rules to determine primary and secondary benefits. After the primary plan has been applied, the secondary plan may cover up to the allowed expense according to the plan's payment guidelines.

COB Claims Submitted Electronically

If you will be submitting COB claims electronically, please note that all required information must be completed for consideration. This includes, but is not limited to:

- Primary Plan name
- Primary Plan member ID
- Paid/Finalized date on primary Plan explanation of benefits (EOB) or explanation of payment (EOP)
- Primary allowed amount
- Primary paid amount
- Primary patient responsibility
- Remark/Adjustment code
    - **Note:** This is **required** if no primary payment was issued.

COB Claims Submitted by Mail, Fax, or Secure Email

If you will be submitting COB claims by mail, fax, or secure email, you must submit a current CMS-1500 (for professional claims) or UB-04 (for inpatient and/or facility-based program claims), along with the Primary Plan EOB and the Primary Plan EOP. Please note, all information identified above for electronic submissions must be legible on the EOB/EOP submitted for consideration.

Any additional information needed will be requested in writing, which will include the specific claim being reviewed and the information required to process the claim.

Corrected Claims

Corrected claims should be submitted within 30 business days from the date the original claim was finalized. This date should be included on the EOB/EOP received from the original submission.

Please note, corrected information may change the adjudication decision. All claims are processed based on Plan coverage, limitations, and exclusions present on dates services were rendered. Additionally, if we have any questions about the corrected information, you may be required to submit additional documentation.

If you have not received notice of adjudication, please confirm claim receipt and status. This can be accomplished by contacting our representatives or logging into our Provider Portal.

Overpayments

If we identify an overpayment has been made, we will notify you in writing. The overpayment/refund request letter will identify the applicable member information, date(s) of service, original payment amount(s), corrected payment amount(s), and funds due.

Please note, for plans where we are not the final payer (e.g., payment is issued to you by the Third-Party Administrator (TPA) for the member's Plan), corrected claims/pricing would be completed by SimpleMSK. The TPA will send overpayment requests and any funds will be issued back to them, as directed in the letter you receive.

If you disagree, you should notify us in writing within 30 business days of receipt. This date will be included on the overpayment/refund request letter.

Please refer to Provider Dispute Resolutions, within this section, for additional information. If you do not contest or object a notice of overpayment, your reimbursement should be issued within 30 business days of receipt.

Provider Dispute Resolutions

If you disagree with a payment decision, you can file a Provider Dispute requesting reconsideration of payment decisions you disagree with. This process does not address claims corrections needed, claim inquiries, or requests for claim information.

Please verify ahead of submission that we have not requested additional information related to the decision being disputed. If additional information was requested, please submit the information with a corrected claim for reprocessing.

Provider dispute resolutions must be submitted within 90 days from the date the original payment decision was finalized. The finalized date is determined by the date listed on the EOB/EOP received. The dispute must be submitted on the provider's letterhead and include the following information:

- Rendering provider name
- Payee tax ID (TIN)
- Member/Patient name
- Member/Patient date of birth
- Member/Patient ID number
- Date(s) of service being disputed
- Claim number(s)
- Copy of theEOB or EOP
- Summary of Service(s)/Dispute (please note, there should be a clear and specific explanation of what you believed was processed incorrectly.)
- Supporting documentation, as applicable, including, but not limited to: medical records, other Plan payment information, proof of timely filing, etc.

If the individual filing the appeal is not the provider identified on the claim, you must also include the following information:

- Name of individual filing appeal
- Relationship to member/patient
- Contact information for individual filing appeal

Disputes can be submitted by mail, fax, or secure email. When a dispute is received, you will receive acknowledgement of receipt.

Most disputes are resolved within 45 business days. If additional information is needed, please allow an additional 45 business days from the date documentation is received.

Forms

Use the forms below to submit a pretreatment request for your patients, as needed. Simply click on the links below or go to https://www.simpletherapy.com/en/simpleMSK-forms/

- Chiro Pretreatment Request
- ST Habilitative Pretreatment Request
- ST Rehab Pretreatment Request
- OT Habilitative Pretreatment Request
- OT Rehab Pretreatment Request
- PT Habilitative Pretreatment Request
- PT Rehab Pretreatment Request
- ACU Pretreatment Request