13
Summer

Provider News

Please share our news.

This newsletter is designed to communicate pertinent health plan information to contracted health care administrative staff as well as medical staff. So, if you are the office person receiving our newsletter, PLEASE share this newsletter with everyone in your office. If you would like us to send you additional paper copies or an electronic copy to make routing easier, please contact the newsletter editor at 920-617-6305 or email: GBNetworkDevelopmentDept @AriseHealthPlan.com

TTY/TDD users may contact us at 920-347-9390 (local) or 1-888-332-0144 (toll free).

HMO/POS Commercial Products

iCES Update

Arise Health Plan enhanced its claim auditing abilities with a transition from the current claims editing system, McKesson's ClaimCheck® to OptumInsight's claims editing system iCES®.

The change in software will enable us to better manage cost effective health care and delivery and equitable, efficient and consistent reimbursement, based upon recognized third party publications such as CCI, CPT, AMA, CMS or other professional organization recommendations.

Access to the online web based application, which allows providers the ability to review clinical rules and rationale, will still be available through **www.WeCareForWisconsin.com** web site. Your current user name and password remain the same.

this issue

Clinical Practice Guidelines P.2
Medical Management Contact P.2
Pre-Service Authorizations FAQ P.3
Practitioner Rights Pertaining to Credentialing P.3
Availability of Medical Policy Guidelines P.4
Denial Notices P.4
Prescription Drug Information P.4

Clinical Practice Guidelines

Arise Health Plan makes Clinical Practice Guidelines available on our web site at **WeCareForWisconsin.com**. The guidelines have been created by nationally recognized and accredited organizations. The primary purpose of the guidelines is to continuously improve the quality of preventative health care for Arise Health Plan members and those affected with the illnesses targeted by these guidelines.

Clinical Practice Guidelines are designed to assist physicians and other practitioners by providing an analytical framework for the evaluation and treatment of patients with specific clinical circumstances. They are not intended to replace professional judgment or to establish a protocol for patients with a particular condition. A guideline will rarely establish the only approach to a problem.

Clinical Practice Guidelines have a sound scientific basis, such as clinical literature and expert consensus. The selected guidelines are from nationally recognized organizations and have been reviewed by Advisory Committees.

Practice guidelines are not intended to determine plan benefits and do not reflect coverage. Benefit coverage varies by group and should be verified prior to services being rendered.

The National Committee for Quality Assurance (NCQA), which is the accrediting organization for managed care plans, requires the adoption of clinical practice guidelines as an important part of the accreditation process. In addition, these guidelines are helpful in demonstrating to our providers and members the quality of care we provide to those who purchase our services.

These guidelines are reviewed for updates annually. Also, relevant new guidelines will be added regularly as they become available. It is my hope and expectation that these guidelines will be helpful to you in the care of your patients.

Medical Management Contact Info

The Medical Management staff is available during our normal business hours, Monday through Friday, 8:00 am to 4:30 pm. To obtain information from our Medical Management department related to a pre-service authorization or to discuss Utilization Management decisions, please see the instructions below:

- **Faxing**: Please send to 920-490-6943, attention Medical Management
- **Calling during Business Hours:** Please call 920-490-6901 or 1-888-711-1444 extension 6901. Language assistance is available, if needed.
- **Leaving a voicemail outside of business hours:** Please clearly state your first and last name, your member number, the reason you are calling and a contact number and time we can reach you. A member of the Medical Management department will return your call within one business day.

For members who are hearing or speech impaired TDD/TTY contact number: 1-888-332-0144.

Pre-Service Authorization FAQs

What Is a Pre-service Authorization?
A pre-service authorization is the process of receiving written approval from Arise Health Plan for certain services prior to being rendered. The pre-service authorization is a written form submitted by a participating practitioner. Services are still subject to all plan provisions including, but not limited to, medical necessity and plan exclusions.

When Is a Pre-service Authorization Needed?
Pre-service authorization is required for all nonparticipating practitioners/providers and tertiary care specialists/our facilities. Pre-service authorization is required for specialized services including:

- Inpatient stay in a Hospital, Skilled Nursing Facility (Nursing Home), or Birthing Center
- Transplants
- Home Health Care
- Hospice Care
- Durable Medical Equipment over $500 or any Durable Medical Equipment rentals
- Home Infusion
- Prosthetics over $1,000
- New Medical or Biomedical Technology
- New Surgical Methods or Techniques
- Non-emergency ambulance transportation
- Genetic counseling, studies and testing

Before seeking medical services, members should call Arise Health Plan Member Services at (920) 490-6900 or toll-free (888) 711-1444, option 1, to verify that the pre-service authorization request has been approved.

Services that Do Not Require Pre-Service Authorization

- Services performed by a participating practitioner/provider.
- Emergency care or urgent care at an emergency or urgent care facility.
- Covered radiologist, pathologist, and anesthesiologist services at a participating facility.
- Services performed by a Participating Provider, including a Participating Provider who specializes in obstetrics or gynecology, unless for those services noted above

Whose Responsibility Is It To Obtain the Pre-Service Authorization?
It is ultimately the member's responsibility to make sure the pre-service authorization request is submitted and approved by Arise Health Plan prior to receiving services. Pre-service authorization forms are available to print on Arise Health Plan's website **www.WeCareForWisconsin.com**.

Practitioner Rights Pertaining to Credentialing

Credentialing of practitioners is performed by the Arise Health Plan Credentialing Department upon initial contracting of practitioners, and every three years thereafter. Practitioners undergoing the credentialing process have the following rights:

- You have the right, upon request, to be informed of the status of your application at any time, and to review a summary of information obtained by the Credentialing Department for the purpose of evaluating your application, excluding confidential peer references and evaluations or information that is peer review protected.

- You will be promptly notified of information that varies significantly from the information you have provided and be given the opportunity to submit updated/additional documentation or corrections. The correction of erroneous information must be done, in writing, within ten (10) days of being notified of the varying information by the Credentialing Department. The Credentialing Department is not obligated to reveal the source of information if disclosure is prohibited by law.

- You will be notified of the Credentials Committee decision regarding your application via written letter within 60 calendar days of the committee's credentialing or recredentialing decision.

If you have any questions regarding the Arise Health Plan credentialing process, please contact the Credentialing Department at 920-490-6952.

Availability of Medical Policy Guidelines

Physicians and other practitioners may obtain the medical policy guidelines used for making medical coverage determinations for an Arise Health Plan member under their care. If you have received a determination and would like to review the medical policy guidelines used in that determination, you may contact us.

To obtain medical policy guidelines for a specific subject through the Medical Management Department of Arise Health Plan, submit your request via telephone, fax, or in writing to Arise Health Plan, Medical Management Department, P.O. Box 11625, Green Bay, WI 54307-1625, Telephone (920) 490-6900 or 888-711-1444 toll-free, Fax (920) 490-6943. If applicable, please include the patient name and member number along with the subject (procedure/service/treatment) for which you are requesting the medical policy guidelines.

The medical policy guidelines are an informational resource and not an authorization, an explanation of benefits, or a contract to provide benefits. Receipt of benefits is subject to satisfaction of all terms and conditions of the member's contract in effect at the time services are rendered. Medical technology is constantly changing, and we reserve the right to review and update our medical policy guidelines as necessary.

We hope that by providing the specific medical policy guidelines upon request, you may better understand the basis for a decision. Our medical policy guidelines are based on sound medical and clinical evidence and adopted with the involvement of appropriate medical specialists. If you have comments or suggestion regarding any specific guideline, these may be forwarded in writing to Arise Health Plan, Medical Management Department, P.O. Box 11625, Green Bay, WI 54307-1625.

Denial Notices

Physicians and other practitioners may contact a physician, appropriate behavioral health, or pharmacist reviewer to discuss medical necessity denial decisions for an Arise Health Plan member under their care. If you have received a denial notice and would like to discuss that denial determination and review the medical policy guidelines used, you may contact the Medical Management Department of Arise Health Plan via telephone, fax, or in writing:

Arise Health Plan Medical Management Dept.
P.O. Box 11625
Green Bay, WI 54307-1625
(920) 490-6900 or toll free 888-711-1444
Fax (920) 490-6943

Prescription Drug Program Information

Information regarding Arise Health Plan's Prescription Drug Program can be found on our website. Elements described include how the formulary is developed and maintained, the pre-authorization program for select drugs, generic substitution, and appropriate-use features like drug interaction monitoring and quantity thresholds.

If you would like a copy of this information, please contact Member Services at 1-888-711-1444.