Provider Manual

January 2014

Commercial HMO/POS Products

SECTION 1: WELCOME

Arise Health Plan Welcomes You as a Partner

The Arise Health Plan Provider Manual is designed specifically for Arise Health Plan Providers. It was prepared for you by Arise Health Plan to promote a clear understanding of Arise Health Plan's policies and procedures, including provider services, pre-service authorization, claims and eligibility.

This manual should be used as a reference guide. Its purpose is to answer some of the questions you may have regarding Arise Health Plan operations.

As changes evolve over time, this manual will be revised on a routine basis. Arise Health Plan reserves the right to revise or alter the material and information detailed in this manual.

You are always welcome to contact the Network Management Department with questions or concerns by calling (920) 617-6325 or toll free (888) 711-1444 ext. 6325, 8:00 a.m. to 4:30 p.m. Monday through Friday, Central Standard Time.

Arise Health Plan
PO Box 11625
Green Bay, WI 54307-1625

SECTION 2: UPDATES TO THE PROVIDER MANUAL

Section 31: Pages 55-59	Updated and added Modifiers	12/19/2011
Section 31: Page 57	Updated QS Modifier percentage	05/04/2012
Section 31: Pages 53-55	Added ICES language	04/22/2013
Section 12: Pages 18-20	Updated Definitions	10/01/2013
Section 15: Pages 23-24	Added Pediatric Vision Management	10/01/13
Section 25: Pages 37-38	Revised	10/01/2013
Section 29: Pages 46-47	Revised	10/01/2013
Section 32: Pages 54-56	Revised	10/01/2013
Section 35: Page 60	Added Compliance with Program/Provider Manual	10/01/2013
Section 31: Page 49	Revised Electronic Claims Submission	1/31/14

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SECTION 4: ABOUT US & OUR HISTORY

On June 1, 2005, Prevea Health Plan was purchased by WPS Health Plan Inc., a wholly owned subsidiary of Wisconsin Physicians Service Insurance Corporation (WPS Health Insurance). WPS Health Insurance has deep roots in Wisconsin, grounded in events that occurred in the mid-1940s. It was a time when many people were having difficulty paying for necessary health care. In response, the State Medical Society of Wisconsin developed a low-cost insurance product, called the Wisconsin Plan, which permitted Wisconsin residents to budget the costs of health care. In 1946, the Medical Society established Wisconsin Physicians Service (WPS) to market and administer the plan.

The acquisition by WPS Health Insurance gave Arise Health Plan the resources, technologies, and experience needed to introduce innovative health plan products, and offered businesses and their employees more insurance options. It also allowed Arise Health Plan the opportunity to remain a Wisconsin based company with strong ties to the local communities in which we serve.

On November 1, 2006, WPS Health Plan, Inc. changed its dba (doing business as) name from WPS Prevea Health Plan to Arise Health Plan. We will continue to use our corporate name abbreviation of WPSHP.

Arise Health Plan was founded to promote health and provide access to quality health care in a caring and responsible partnership. The health care marketplace has changed dramatically, but our mission and values remain unchanged.

Arise Health Plan is not only your health plan provider, but as a resident of Wisconsin, we are your neighbor, too. We are part of the community and know that we will see you at the grocery store and the kids' baseball games. We want to look you in the eye and know that we are doing right by you and your employees. For us, business is personal.

To stay in touch with our neighbors' health care needs, and to remain accessible and responsive, we only do business in Wisconsin. Our health plan operations and staff are based in Green Bay. Medical decisions for our members are made in Green Bay, with local physicians responsible for the care they provide to their patients.

Arise Health Plan is not only focused on our customers' health; we also care about the health of the communities we call home. Arise Health Plan actively supports local community organizations like United Way, The Salvation Army, The Volunteer Center, and many more.

Our comprehensive provider network includes physicians, specialists, clinics, and hospitals across Northeast and Central Wisconsin that our customers know and trust.

Arise Health Plan offers a broad range of insurance and employee benefit products to meet the needs of our group and individual customers, from traditional HMO and POS plans and self-funded administration, to consumer-driven options.

The National Committee for Quality Assurance (NCQA) awarded Arise Health Plan an accreditation status of Commendable. Our accreditation status was awarded after an evaluation of all aspects of our plan, including preventative health services, satisfaction, physician credentialing and quality improvement.

SECTION 5: MAIN CONTACT INFORMATION

Phone Numbers
Main Number: (920) 490-6900 or toll free (888) 711-1444
Main Fax: (920) 490-6942

Business Hours
Monday through Friday 8:00 a.m. – 4:30 p.m. CST

Office Location
421 Lawrence Drive, Suite 100
De Pere, WI 54115

Mailing Address
P.O. Box 11625
Green Bay, WI 54307-1625

Our Web Site: www.WeCareForWisconsin.com

MEMBER SERVICES TEAM

Phone: (920) 490-6900 or toll free (888) 711-1444
Fax: (920) 490-6942

Call the Member Services Team for:

- Coverage verification
- Provider verification
- Member and Provider questions regarding claim processing or payment
- Benefit and policy determination

MEDICAL MANAGEMENT TEAM

Phone: (920) 490-6901 or toll free (888) 711-1444, ext. 6901
Medical Fax: (920) 490-6943

SECTION 5: MAIN CONTACT INFORMATION

Call the Medical Management Team for pre-service authorization and status of:

- Inpatient stay in a Hospital or Skilled Nursing Facility (Nursing Home)
- 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

NETWORK MANAGEMENT & PLAN DEVELOPMENT CONTRACTING

Phone: (920) 617-6325 or toll free (888) 711-1444 ext. 6325
Fax: (920) 490-6923
Team E-mail: **GBNetworkDevelopmentDept@AriseHealthPlan.com**

Call the Network Management for:

- Provider additions, terminations, & changes
- Fee schedule questions
- Assistance with provider issues
- Provider directory/website listings

Plan Development Contracting:
Phone: (920) 617-6325
Fax: (920) 490-6944

Call the Plan Development for:

- Contractual questions

CREDENTIALING TEAM

Phone: (920) 490-6952 or (920) 490-6954 or toll free (888) 711-1444 ext. 6952 or 6954
Fax: (920) 490-6955
Team E-mail: **GBCredentialingDept@AriseHealthPlan.com**

Call the Credentialing Department for:

- Initial Credentialing and Recredentialing information

SECTION 6: MEMBER PRIMARY CARE ACCESS MODEL

Primary Care Practitioners (PCP's) are the core of Arise Health Plan. The objective of our Primary Care Model of Care is to guide members into an ongoing relationship with a PCP. The PCP is the individual responsible for coordinating the medical care for each member. We define PCP's as:

- Family Practice
- General Practice
- Internal Medicine
- Obstetric/Gynecology
- Pediatrics

We believe this PCP model provides members with medical services within a timeframe that allows safe treatment of emergency and emergent conditions, and which maintains effective preventative health care practices.

A list of PCP's is available for the member on our website or in our provider directory. It is important for the member to always identify themselves as an Arise Health Plan member whenever they are making an appointment with a provider.

Arise Health Plan members will have reasonable access within Arise Health Plan's service area to care and services with respect to geographic location, hours of operation, and waiting times.

Arise Health Plan will contract with a sufficient number of PCPs, specialists, and other health care providers who are in the geographic service area, to meet the medical needs of our plan members.

SECTION 7: APPOINTMENT SCHEDULING GUIDELINES

Member requests appointment for care.

Clinic receptionist, nurse, or specified person determines type of care (if unable to determine type of care or patient/member has additional concerns, the situation is referred to the nurse or physician).

- PREVENTIVE CARE--Involves asymptomatic patient/member; visit is for wellness, annual exam, scheduled immunization or other non-illness/injury related issue.

- ROUTINE PROBLEM--Involves patient/member with stable non-urgent symptoms or conditions which: are not likely to change in the next 48 hours; do not cause concern about an illness or injury; do not interfere with normal daily activities.

- URGENT PROBLEM--Involves patient/member with active symptoms or condition which: are likely to escalate in the next 48 hours; cause concern about an illness or injury; interfere with normal daily activities.

- EMERGENT PROBLEM--Involves severe active symptoms or conditions which: are life threatening; will become life threatening if not treated; require medical care immediately or within the next two hours.

Clinic receptionist schedules appointment and strives to meet the following standards.

Type of Medical Appointment	Preventative Care	Routine Problem	Urgent Problem	Emergent Problem
Max Time from Patient Request to Appointment Date	30 days	7 days	Same Day Access	Immediate Access

Type of Behavioral Care Appointment	Routine Care	Urgent Care	Non-Life-Threatening Emergency
Max Time from Patient Request to Appointment Date	10 Business Days	48 Hours	6 Hours

A consult is an appointment made at the request of the PCP. The clinic receptionist schedules a consult appointment based on the same guidelines set forth for Preventive Care, Routine Problem and Urgent Problem as defined above.

If the PCP or consulting physician cannot see the patient within the time frames indicated by the clinic and Arise Health Plan guidelines, an appointment will be offered with an alternate physician/same site, or if unavailable, then with an alternate physician/different Arise Health Plan site. The patient may decline the alternate arrangement and accept a delayed appointment with the PCP.

SECTION 8: SITE VISIT REVIEW PROCESS

When requested by the Medical Director of Quality, a site visit is scheduled and conducted by an Arise Health Plan reviewer, at which time a site visit form is completed.

The site visit review process includes, but is not limited to, an assessment of the sites:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Availability of appointments
- Adequacy of medical/treatment record keeping and
- Confidentiality of records.

The Arise Health Plan reviewer will document and score the results from the site visit and medical/treatment record keeping practices. The performance standard established by Arise Health Plan is 90%-100%. Results of the site visit will be made part of the credentials file of each practitioner located at the site.

If the performance standards are met at the site, a copy of the site visit results will be sent to the site manager/designee.

If the percentage of all items is less than 80%, a copy of the site visit results, outlining the deficient areas, and a proposed corrective action plan will be forwarded to the site manager/designee. The site manager/providers will be given the opportunity to respond to the corrective action plan prior to review by the Complaints Committee. The Complaints Committee will then review the site visit results, corrective action plan, and response, if any, from the site manager. The site must implement the corrective action plan within six months of the initial visit. Arise Health Plan will revisit the site at least every six months until the site achieves the performance standard.

If the site does not achieve the performance standard due to lack of written policies and procedures, the site manager and/or providers will be required to submit written policies to Arise Health Plan within six months of the initial visit. Another site visit is not required to view policies.

SECTION 9: MEDICAL RECORD REQUIREMENTS

The medical record requirements include:

- Patient's name or ID number on each page
- Personal/biographical data to include the address, employer, home and work telephone numbers, and marital status
- A problem list to indicate significant illnesses/medical conditions
- Notation of medication allergies, adverse reactions or documentation of no known allergies
- A medication list
- An immunization record if primary care
- The medical record keeping system is organized, as evidenced by easily identifiable, individualized records.
- There is a policy on the availability of medical records that addresses the ease of retrieving, timeliness of completion, and release of information.
- Patient information is kept confidential as evidenced by written policies/procedures and storage of medical records in an area not accessible to the public.

Information filed in medical records includes, but is not limited to:

- All services provided directly by a PCP
- All ancillary services and diagnostic tests ordered by a practitioner
- All diagnostic and therapeutic services for which a member has been referred by a practitioner, such as:
    - Home health nursing reports
    - Specialist reports
    - Hospital discharge reports
    - Physical therapy reports

The performance goals established by Arise Health Plan for participating practitioners and physicians are 90 - 100%.

SECTION 10: OVERVIEW OF MEDICAL MANAGEMENT

The Medical Management Program is designed to monitor the appropriateness of all medically necessary and covered services for pre-service care, concurrent review, and post-service care delivered to Arise Health Plan members.

The program has been developed in collaboration with Arise Health Plan contracted health care providers and the Arise Health Plan Medical Management team. Promoting optimal practice, while being sensitive to the current structure of the local delivery systems, is the strategy of our Medical Management Program. All components of the program comply with Federal and State regulations and strive to meet the nationally recognized utilization standards of the National Committee for Quality Assurance (NCQA). The program is designed to make utilization decisions affecting the health care of members in a fair, impartial and consistent manner. The main goal of the Medical Management Program is to oversee and ensure the quality of relevant care while promoting appropriate utilization of medical services and plan resources.

The objectives of the Medical Management Program are to:

Provide a structured process to continually monitor and evaluate the delivery of health care and services to our members by:

- Establishing system-wide health management processes across the continuum of care.
- Establishing a process for provider feedback regarding utilization.
- Monitoring indicators to detect possible under- and over-utilization.
- Periodic auditing of denial decision timeliness.
- Conducting inter-reviewer reliability audits of all Case Management Specialists and the Medical Director.

Improve clinical outcomes by:

- System-wide collaboration to identify, develop, and implement clinical practice guidelines and programs, which address key health care needs of the members.
- Implementation of clear, consistent Medical Management requirements and key indicators of success.
- Implementation of Behavioral Health management processes.
- Development of mechanisms to measure and implement actions to improve under- and over- utilization.
- Collaboration with the Quality Improvement (QI) Committee/department, Medical Director, and Manager of Medical Management to assess and implement actions to improve continuity and coordination of care.

Improve practitioner and member satisfaction by:

- Assessing practitioner and member satisfaction with Medical Management policies and procedures.
- Promoting appropriate utilization of Arise Health Plan resources through efficiency of service.

SECTION 10: OVERVIEW OF MEDICAL MANAGEMENT

Meet or exceed established quality standards by:

- Complying with NCQA standards for the accreditation of Managed Care Organizations.
- Measuring program performance in accordance with the Health Employer Data Information Set (HEDIS) specifications.

The scope of the Medical Management Program consists of the following components:

- Primary Care A Model of Care
- Pre-service Authorization Determination of Medical Services
- Concurrent Review Decisions
- Post-Service Decision Determination
- Case Management Program
- Behavioral Health Management Program
- Chiropractic Care Management Program
- Pharmacy and Specialty Drug Management Program
- Emergency Services
- Technology Assessment
- Affirmative Statement on Incentives
- Reporting
- Grievances and Appeals
- Radiology Benefit Management Program
- Satisfaction with the UM Process

The Medical Management Program is supported by the following resources/tools:

- Nationally published and locally developed Utilization Management Criteria
- Clinical Practice Guidelines
- Policies and Procedures
- Clinical Experts
- Literature
- External Review
- Definitions from the Certificate of Coverage
- Conference/Seminars

The Medical Management department collects data on practitioner satisfaction with the Utilization Management process and reports this information to the Quality Improvement Committee for review and action, as they deem necessary.

SECTION 11: MEDICAL MANAGEMENT PROGAM

Arise Health Plan operates under a Primary Care model of health care. The Primary Care model provides high quality health care by increasing opportunities for continuity of care; coordination of care among multiple providers; and effectively using the services of PCP's, specialty physicians, and other providers.

- Arise Health Plan members must select a PCP upon enrollment in the Health Plan.
- PCP's may be the following specialties: Family Practice, Pediatrics, General Practice, Internal Medicine, or Obstetrics/Gynecology.
- Members have direct access to participating plan PCP's and specialists.
- Specialists may refer to another specialist upon concurrence with the member's PCP. The member is responsible to have the PCP or specialist submit a written pre-service authorization request to Arise Health Plan for all nonparticipating practitioners and tertiary care specialists/facilities. Specialists who see a member through pre-service authorization are accountable for communicating the results of the consultation and recommended treatment to the member's PCP.
- Participating Specialists performing a procedure or providing a service, which requires a pre-service decision, are responsible for notifying Arise Health Plan and discussing the member's care with the member's PCP.
- The PCP is responsible for assessing, directing and coordinating the members need for specialty care.

The Medical Management Program is developed and revised by the Medical Management Department. The program is reviewed and approved annually by the Quality Improvement Committee.

The Medical Director has responsibility for the key aspects of the Medical Management program, such as setting policies, reviewing cases, and participating in a variety of Medical Management Committees and the Quality Improvement Committee meeting. The Medical Director oversees the inpatient case management program, the ambulatory case management, and the pharmacy benefit management programs. The Medical Director makes the final decision for all medical necessity denial decisions for inpatient, concurrent, pre-service, and post-service care.

All activities and initiatives within Medical Management are coordinated within the framework of the Quality Improvement Program. The Medical Director is the Chair of the Quality Improvement Committee.

The Medical Director may consult with an appropriate board-certified specialist if a medical necessity review is outside of the Medical Director's scope of expertise.

Arise Health Plan has a participating behavioral health practitioner involved in the Behavioral Health Program in conjunction with the Medical Director. His/her role is to oversee and provide professional expertise to continually improve the Behavioral Health Program. The Medical Director consults with this practitioner on an as needed basis regarding behavioral health issues/reviews.

SECTION 11: MEDICAL MANAGEMENT PROGRAM

Medical Management Confidentiality

Member health information that is identifiable, including medical records, claims, benefits and administrative data, obtained in connection with the performance of duties in utilization management, shall not be revealed or disclosed in any manner or under any circumstance, except to a member's attending physician.

Information required to study and evaluate the quality of care and/or policies or services focus on members shall be made available only to the persons directly involved in presenting, reviewing, evaluating, or acting upon the information.

Program descriptions, manuals, forms, and all related documentation are considered to be proprietary business information, and shall be treated as confidential.

SECTION 12: MEDICAL MANAGEMENT DEFINITIONS

These definitions are taken from Arise Health Plan certificates, which may vary depending upon the type of plan.

Experimental or Investigational means the use of services, treatment, supplies, or facilities that include, but are not limited to, one of the following:

(a) Are not currently recognized as accepted medical practice as determined by Our Medical or Chiropractic Director;
(b) Were not recognized as accepted medical practice at the time the charges were incurred, as determined by Our Medical or Chiropractic Director;
(c) Have not been approved by the United States Food and Drug Administration upon completion of Phase III clinical investigation;
(d) Are used other than for the approved usage by the United States Food and Drug Administration;
(e) Have not successfully completed all phases of clinical trials, unless required by law;
(f) Is a treatment protocol based upon or similar to those used in on-going clinical trials; or
(g) Based on prevailing peer reviewed medical literature in the United States, there is failure to demonstrate that the treatment is safe and effective for the condition, and there is not enough scientific evidence to support conclusions concerning the effect of the drug, device, procedure, service, or treatment on health outcomes.

A service, supply, treatment or facility may be considered Experimental or Investigational and not Medically Necessary, even if the provider/Practitioner has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition.

The evidence must consist of well-designed and well-conducted investigations published in peer-review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence must demonstrate that the drug, device, procedure, service, or treatment can measure or alter the sought after changes to the disease, Injury, Illness, or condition. In addition, there must be evidence or a convincing argument based on established medical research that such measurement or alteration affects that health outcome.

Opinions and evaluations by national medical associations, consensus panels, other technology evaluation bodies, or outside independent review organizations are evaluated according to the scientific quality of the supporting evidence and rationale.

References used in the evaluation include, but are not limited to, The American Cancer Society, The American Medical Association, FDA, U.S. Department of Health & Human Services, Apollo Review Criteria Guidelines, Milliman Care Guidelines, National Library of Medicine Search, National Institutes of Health, Pubmed (Medicine), The Hayes Directory of New Medical Technologies, Cochrane Library, National Comprehensive Cancer Network, National Guidelines Clearinghouse, and/or the American Academies or Colleges of various Physician specialties.

SECTION 12: MEDICAL MANAGEMENT DEFINITIONS

A service, supply, treatment, or facility may be considered Experimental or Investigational and not Medically Necessary even if the provider or Practitioner has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

Medically Necessary means services, treatment, supplies, or facilities that We determine to be:

(a) Consistent with and appropriate for the diagnosis or treatment of the Covered Person's Illness or Injury;
(b) Commonly and customarily recognized and generally accepted by the medical profession in the United States as appropriate and standard care for the condition being evaluated or treated;
(c) Substantiated by the clinical documentation;
(d) The most appropriate and cost effective level of care, compared to other levels of intervention, including no intervention, which can safely be provided to the Covered Person. Appropriate and cost effective does not necessarily mean the lowest price;
(e) Proven to be useful, likely to be successful, yield additional information, or to improve clinical outcome; and
(f) Not primarily for the convenience or preference of the Covered Person, his or her family, or any provider.

A service, supply, treatment or facility may not be considered Medically Necessary, even if the provider or Practitioner has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition.

As defined by NCQA, the following definitions are used by Medical Management to assist in making authorization decisions.

Pre-service authorization: any case or service that the organization must approve, in whole or in part, in advance of the member obtaining medical care or services. Preauthorization and pre-certification are pre-service authorizations.

- **Post-service decision:** any review for care or services that have already been received, an example, retrospective review.

Urgent Care: any request for care or treatment with respect to the application of the time periods for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- Could seriously jeopardize the life, health or safety of the member or others due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Concurrent review decision: any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

SECTION 13: PRE-SERVICE AUTHORIZATION

What is a Pre-service Authorization?

A pre-service authorization is the process of receiving written approval from Arise Health Plan for certain services or products 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 non-participating practitioners/providers and tertiary care specialists/facility. Pre-service authorization is required for specialized services including:

- All low back pain referrals to Orthopedic Surgery, Neurosurgery, or Pain Management Specialists (State of Wisconsin members only)
- Inpatient stay in a Hospital or Skilled Nursing Facility (Nursing Home)
- 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, to verify that the pre-service authorization request has been approved.

A Pre-Service Authorization is not required for:

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

The employer may require the member to access behavioral health care through an employee assistance program (EAP). If this is the case, a pre-service authorization may be required for behavioral health care.

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.

SECTION 13: PRE-SERVICE AUTHORIZATION

How Will Claims be Paid if Authorized Care is Received from a Non-Participating Provider?

Maximum Allowable fee levels will apply to non-participating providers and services rendered. This means that the member is responsible for any charge that exceeds the Maximum Allowable fee level for authorized services received from non-participating providers.

Go to: www.WeCareForWisconsin.com under “Provider Information” to print a paper copy of the “Pre-Service Authorization Request Form”.

Additional paper copies of Arise Health Plan Pre-Service Authorization Request Forms can be requested from Arise Health Plan Member Services at:

Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625

Phone: (920) 490-6900 or toll free (888) 711-1444
Fax: (920) 490-6942

Note: A Pre-Service Authorization Form can be viewed on the following page.

SECTION 13: PRE-SERVICE AUTHORIZATION

PRE-SERVICE AUTHORIZATION REQUEST

Approved _____ Amended_____ Denied_____
Reason: _____
_____
_____
Medical Staff/Date: _____

ALL PRE-SERVICE AUTHORIZATION REQUESTS ARE SUBJECT TO REVIEW. Under the provision of the plan, all authorizations must be approved by the Plan Medical Director or an authorized designee prior to dates of service requested. Individuals may be subject to additional out-of-pocket expense up to the limits of their plan, if authorization is not approved prior to services received or if receiving services from a nonparticipating provider. **PRE-SERVICE AUTHORIZATION DOES NOT APPLY TO SERVICES OR CHARGES WHICH ARE EXCLUDED BY THE PLAN.**

****RETROACTIVE AUTHORIZATION REQUESTS WILL NOT BE AUTHORIZED****

Please Complete all sections:

Patient Name: _____ Date of Birth: _____
Subscriber Name: _____ Subscriber #: _____
Patient Home Phone #: _____ Employer: _____

Referred To: _____
Provider Name

_____
Address

_____
Telephone Number

Working Diagnosis / ICD9: _____

Clinical history including pertinent diagnostic testing/treatment necessitating pre-service authorization request/extension:

_____
_____
_____
_____

Authorization request for: _____ Consultation _____ Lab, X-Ray, Testing _____ Treatment/Therapy _____ Surgery

Limitations/restrictions on the services authorized: _____
_____

This authorization request is for the following: _____ visits from _____/_____/_____ to _____/_____/_____

*Special requests: _____

Referred By: _____ MD
Print Name

_____ MD
Physician's Signature

_____
Date

_____
Physician Contact Phone Number

_____
Physician Office Contact Person

_____
Telephone Number

ALL HOSPITAL INPATIENT ADMISSSIONS REQUIRE PRE-SERVICE AUTHORIZATION:
Call1-888-711-1444 toll-free or 920-490-6900 local

Fax or Mail to:
Arise Health Plan
PO Box 11625 · Green Bay, WI 54307-1625
1-888-711-1444 toll-free, 920-490-6900 local
Fax: 920-490-6943

For office use only:
Case # _____
Completed by: _____

MMD-REF-0001
06/09

WPS Health Plan, Inc.

SECTION 14: PRE-SERVICE AUTHORIZATION DETERMINATION

The Medical Management Program requires pre-service authorization determination of all services referred to inpatient facilities (including rehabilitation and skilled nursing facilities), non-participating practitioners/providers, tertiary care specialist/facility and providers, and for other select services. These services may be reviewed for medical necessity, potential redirection to an appropriate participating practitioner/ provider, and/or coordination of care/services.

- Requests may be submitted by facsimile, telephone, or by mail.
- All data and relevant information is obtained, including but not limited to medical records, communications with practitioner or other consultants.
- Relevant information is reviewed using utilization management criteria as described in resources/tools section.
- Inpatient facility care, for example, observation, acute, rehabilitation and/or skilled nursing care, is reviewed prior to or within 24 business hours of admission, then concurrently according to accepted criteria and guidelines.
- Determinations for non-urgent pre-service approval decisions are given to the practitioners and members, via oral, written, or electronic notification, within 15 calendar days of the request. Determinations for non-certifications (denials) in this category (non-urgent) are given within 15 calendar days of the request by written or electronic notification.
- Determinations for urgent pre-service approval decisions are given to the practitioners and members, via oral, written, or electronic notification, within 72 hours of the request. Determinations for non-certification (denials) in this category (urgent) are given within 72 hours of the request via oral, written, or electronic notification.
- Pre-service approval decision letters for select services are sent to the member, the PCP (if applicable), the practitioner to whom the member is being referred, and the facility if appropriate.
- All potential denials for pre-service care, based on medical necessity, are reviewed by the Medical Director and a determination is made by him, or his designee.
- Denials are communicated to the practitioner and member, by telephone or letter. Denial letters are sent to the PCP (if applicable), then referred to practitioner if applicable, and the member.

All written denial determination notifications include:

- The specific reason for the denial.
- A reference to benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.
- An offer to provide a copy of the actual benefit provision, guideline, diagnosis/treatment codes, protocol, or other similar criterion on which the denial decision was based, upon request.
- A description of appeal/grievance rights, including the right to submit written comments, documentation, or other information relevant to the appeal/grievance.
- An explanation of the appeal/grievance process, including the right to member representation, and timeframes for deciding appeals/grievances.
- For urgent pre-service or urgent concurrent denial, a description of the expedited appeal/grievance.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care and ongoing treatment.
- Notice of the External Review Process, if applicable.

SECTION 15: PRE-SERVICE AUTHORIZATION/SPECIAL PROGRAMS/PROVIDER RESPONSIBILITY

Radiology Benefit Management

Arise Health Plan uses National Imaging Associates, Inc. (NIA) (niainc.com), an accredited leader in the management of outpatient radiology benefits. This program is founded on evidence-based medicine.

Procedures Requiring Pre-Service Authorization:

- ► CT SCAN
- ► MRI/MRA
- ► NUCLEAR CARDIOLOGY
- ► PET SCAN

A separate authorization number is required for each procedure ordered.
Note: Inpatient, Emergency Department imaging studies do not require pre-service authorization.

Pre-Service Authorization Process: Call the toll-free number: 1-877-642-0922 or www.RadMD.com.

- The ordering provider submits the clinical information to NIA.
- Relevant information is reviewed using evidence based criteria.
- Authorization is required for each procedure ordered. Procedures performed that have not been properly authorized will not be reimbursed, and the member cannot be balance billed.The ordering provider may request a peer-to-peer discussion with a physician reviewer.

Procedures performed that have not been properly authorized will not be reimbursed, and the member cannot be balance billed.

Specialty Drug Management

Arise Health Plan has engaged Care Continuum to assist with specialty drug management related to treatments administered in the outpatient, office, or home settings. Treatments subject to this program include, but are not limited to specialty drugs like, Remicade, Prolia, Rituxan and other similar medications. A current list of drugs under this program can be found at www.WeCareForWisconsin.com. Care Continuum will review each treatment plan relative to evidence-based guidelines that may contain step-therapy protocols.

Pre-Service Authorization Process: Call toll-free at 1-866-247-5004

Specialty drugs dispensed without proper authorization will not be reimbursed, and the member cannot be balance billed.

Low Back Pain Management

A pre-service authorization determination is necessary for low back Surgery performed by a participating Orthopedic Surgeon or Neurosurgeon when a regimen of optimal conservative care*, as determined by Arise, has been completed. Pre-service authorization must be obtained prior to services being rendered.

SECTION 15: PRE-SERVICE AUTHORIZATION/SPECIAL PROGRAMS/PROVIDER RESPONSIBILITY

All professional services and facility charges provided without proper authorization will not be reimbursed, and the member cannot be balance billed.

The following CPT/HCPCS codes require pre-service authorization:
22220, 22222. 22224, 22532, 22533, 22548, 22556, 22558, 22590, 22595, 22600, 22610, 22612, 22630, 22830, 22857, 22862, 22865, 63001-63017, 63020, 63030, 63040, 63042, 63045-63047, 63050, 63051, 63055, 63056, 63064, 63066, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, S2348, S2350

*Conservative care provided or directed by a non-Orthopedic Surgeon or Neurosurgeon must consist of ALL of the following:

- Chronic low back pain with symptoms present for at least 3 months; AND
- Medical records include documentation of what functional disability is caused by the pain; AND
- Pain is moderate to severe in nature; AND
- Medical records include documentation of pain severity. (Oswestry Score, Pain Visual Analog Scale, or other validated measure); AND
- Failure of at least 6 weeks of conservative measures with two or more modalities including: prescription pharmaceuticals such as non-steroidal anti-inflammatory agents, anticonvulsants and antidepressants; physical and restorative therapies including spinal manipulation, physical therapy with a home exercise program and advice to stay active, chiropractic management with a home exercise program and advice to stay active, and injection therapy. (Epidural steroid injection, intraarticular facet joint injection, and radio frequency ablation.)

If the symptoms require urgent medical care due to severity, the trial of conservative therapy may be waived.

PEDIATRIC VISION MANAGEMENT

Due to the Affordable Care Act (ACA) vision benefits are changing for ***some*** Arise Members. This mainly includes individuals who purchase their own insurance or work for small employers with fewer than 50 employees. The benefit is limited to pediatric vision care for those who are under age 19.

If such product is purchased, the benefits are as follows:

Arise will cover either prescription eyeglasses or contact lenses

Lenses
Coverage is limited to one pair of single vision, conventional bifocal, or conventional trifocal lenses per Calendar Year (1/1 through 12/31) Replacement lenses are not covered.

Frames
Coverage is limited to one pair of frames from a selection of covered frames per Calendar Year. Replacement frames are not covered.

Contact Lenses
Coverage is limited to six pairs of contact lenses every three months. Daily disposable and colored lenses are not covered. Contact lenses are provided in lieu of eyeglasses.

Other lens options and treatments
Other lens options and treatments will only be covered if determined to be Medically Necessary.

Pre-Service Authorization is required for these services:

A. Contact lenses for the following conditions:
   1. Keratoconus;
   2. Pathological myopia;
   3. Aphakia;
   4. Anisometropia;
   5. Aniseiknoia;
   6. Aniridia;
   7. Corneal disorders;
   8. Post-traumatic disorders; and
   9. Irregular astigmatism.

B. Low vision services including the following:
   1. One (1) comprehensive low vision evaluation every five (5) years;
   2. Low vision aids, including only the following:
      a. Spectacles;
      b. Magnifiers;
      c. Telescopes
   3. Follow-up care of four (4) visits in any five-year period.

C. The following lens options and treatments:
   1. Ultraviolet protective coating;
   2. Blended segment lenses;
   3. Intermediate vision lenses;
   4. Standard progressives;
   5. Premium progressives;
   6. Photochromic glass lenses;
   7. Plastic photosensitive lenses;
   8. Polarized lenses;
   9. Standard anti-reflective coating;
   10. Premium anti-reflective coating;
   11. Ultra anti-reflective coating; and
   12. Hi-index lenses.

Effective 1/1/14, Arise has contracted with **Classic Optical Laboratories, Inc.**, to provide **covered eyeglasses and eyeglass component parts** to Arise Members who have a vision hardware benefit.

A selection of frames can be viewed and purchased for display at www.classicoptical.com. This expense is not reimbursed by Arise. **Please call Classic Optical Laboratory at (888) 522-2020 for additional frame information.**

Through the Classic Optical Laboratories website, Providers can place and track orders for covered eyeglasses, verify frame availability and changes to selection. When ordering online, Classic Optical's *smart* ordering form will only allow covered materials and frames to be ordered.

To access these online options, providers are required to have a username and password that can be requested in one of two ways:

- Complete and submit a request form online. To access the request form online, click the "new user" click for login" link in the Login box.
- Call Classic Optical Laboratories, Inc., at (888) 522-2020 during regular business hours (8 a.m. - 6 p.m. CST, Monday through Friday).

Eyeglasses and eyeglass component parts not provided by the Arise contracted vendor will not be reimbursed by Arise without Prior Authorization. Provider cannot bill the member without prior written acknowledgement and consent of the member.

Contact Lenses, provided in lieu of eyeglasses, may be dispensed directly from an Arise Contracted Optometry/Ophthalmology Provider's office. These services should be billed to Arise in the same manner as all other services provided and will be reimbursed according to your Provider Agreement.

- Daily disposable and colored lenses are not covered.
- Lenses billed with V2510-V2531 require review for medical necessity prior to reimbursement.
- Pre-Authorization Request Forms can be found at www.WeCareforWisconsin.com

SECTION 16: CONCURRENT REVIEW DECISIONS

Concurrent review decisions are reviews for the extension of previously approved ongoing care. Examples are the review of inpatient care as it is occurring or ongoing ambulatory care.

Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care being provided, and supports the health care provider in coordinating a member's care across the continuum of health care services.

- Inpatient concurrent review is done telephonically or faxed by Medical Management staff.
- All data and relevant information is obtained, including but not limited to medical records, communications with practitioner or other consultants.
- Relevant information is reviewed using utilization management criteria as described in resources/tools section.
- Inpatient concurrent review is continuous for the duration of the inpatient stay.
- Urgent concurrent review decisions are made, and the practitioner notified, within 24 hours of receipt of the request. Approval decisions are determined by medical management staff and given to practitioners via oral, electronic, or written notification by facility case managers or discharge planner. Denial decisions are given orally or electronically and in writing to practitioner, facility, and member by medical management staff.
- Concurrent review may include staffing with health care professional and/or home visits with home health care agencies.
- Requests to extend a course of treatment previously approved that does not meet the definition of urgent care will be handled as a new request; for example, pre-service or post-service and the appropriate time frames followed.
- All potential denial decisions based on medical necessity related to concurrent review are reviewed by the Medical Director. A determination is made by him, or his designee.

SECTION 17: POST-SERVICE DETERMINATION

Post-service decisions are determinations of medical necessity and/or appropriate level of care when the care has already been received, for example, retrospective review.

Notification of post-service decision denial determinations are given electronically or in writing to the practitioner and member within 30 calendar days of the request.

All data and relevant information is obtained. Relevant information is reviewed using utilization management criteria as described in resources/tools section.

All potential post-service denial decisions based on medical necessity or appropriate level of care are reviewed by the Medical Director and a determination made by him, or his designee.

SECTION 18: CASE MANAGEMENT

Case Management provides a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a member's health needs, using communications and available resources to promote quality, cost-effective outcomes.

Members may be selected for Case Management based on criteria that address various demographics, including but not limited to: age, psycho-social and economic status, support systems, diagnoses, and/or complexity of treatment plan.

Cases may be identified through utilization reports, health promotion activities, claim activity reports, complicated inpatient admissions, and practitioner, provider or member pre-service authorizations and referrals for Case Management.

Case Management is conducted in collaboration with the practitioner, supports the practitioner/member relationship, and promotes adherence to an established treatment plan. Members are notified of their selection for case management.

SECTION 19: BEHAVIORAL HEALTH MANAGEMENT

Behavioral Health Management program provides a mechanism to optimize use of the member's health care benefits while providing high quality integrated health care to members with mental and/or substance abuse disorders. Services include, but are not limited to:

- Inpatient and concurrent certification
- Pre-service request review
- Post-service review
- Case management

The Behavioral Health Management program does not require triage or the pre-service authorization process prior to a member contacting or making an appointment with a behavioral health practitioner. It is the practitioner's responsibility to provide a treatment plan to Arise Health Plan for certain services.

The Behavioral Health Management program requires pre-service authorization determination of all services referred to inpatient facilities (including transitional and intensive outpatient rehabilitation), and non-participating practitioners or providers. These services may be reviewed for medical necessity, potential redirection to an appropriate Arise Health Plan practitioner and/or coordination of care/services.

- Requests may be submitted by facsimile, telephone, or by mail.
- All data and relevant information is obtained, including but not limited to medical records, communications with practitioner or other consultants.
- Relevant information is reviewed using utilization management criteria as described in resources/tools section.
- Inpatient facility care, for example, observation, acute, and rehabilitation is reviewed prior to or within 24 business hours of admission, then concurrently according to accepted criteria and guidelines.
- Determinations for non-urgent pre-service approval decisions are given to the practitioners and members, via oral, written, or electronic notification, within 15 calendar days of the request. Determinations for non-certifications (denials) in this category (non-urgent) are given within 15 calendar days of the request by written or electronic notification.
- Determinations for urgent pre-service approval decisions are given to the practitioners and members, via oral, written, or electronic notification, within 72 hours of the request. Determinations for non-certification (denials) in this category (urgent) are given within 72 hours of the request via oral, written, or electronic notification.
- Pre-service approval decision letters for select services are sent to the member, the PCP (if applicable), the practitioner to whom the member is being referred, and the facility, if appropriate.
- All potential denials, for inpatient and ambulatory care, based on medical necessity, are reviewed by the Medical Director and a determination is made by him, or in conjunction with consultation of the Associate Director of Behavioral Health.

Denials are communicated to the practitioner, member, and PCP if applicable, by telephone or letter. Denial letters are sent to the practitioner, member, and PCP if applicable.

All written denial determination notification include:

- The specific reason for the denial.
- A reference to benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.
- An offer to provide a copy of the actual benefit provision, guideline, protocol, diagnosis/treatment codes, or other similar criterion on which the denial decision was based, upon request.
- A description of appeal/grievance rights, including the right to submit written comments, documentations, or other information relevant to the appeal/grievance.
- An explanation of the appeal/grievance process, including the right to member representation and timeframes for deciding appeals/grievances.
- A description of the expedited appeal/grievance process for urgent pre-service or urgent concurrent denial.
- Notice of the External Review Process, if applicable.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care and ongoing treatment.

Concurrent review decisions are reviews for the extension of previously approved ongoing care. Examples are, the review of inpatient care as it is occurring or ongoing ambulatory care. Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care being provided, and supports the health care provider in coordinating a member's care across the continuum of health care services.

- Inpatient concurrent review is done telephonically or fax by Medical Management staff.
- All data and relevant information is obtained, including but not limited to medical records, communications with practitioner or other consultants.
- Relevant information is reviewed using utilization management criteria as described in resources/tools section.
- Inpatient concurrent review is continuous for the duration of the inpatient stay.
- Urgent concurrent review decisions are made, and the practitioner notified, within 24 hours of receipt of the request. Approval decisions are determined by Medical Management staff and given to practitioners via oral, electronic, or written notification by facility case managers or discharge planner. Denial decisions are given orally or electronically and in writing to practitioner, facility, and member by Medical Management staff.
- Concurrent review may include staffing with health care professional and/or home visits with home health care agencies.
- Requests to extend a course of treatment previously approved that does not meet the definition of urgent care will be handled as a new request,

  for example, pre-service or post-service and the appropriate time frames followed.

- All potential denial decisions based on medical necessity, related to concurrent review, are reviewed by the Medical Director and a determination made by him, or in conjunction with consultation of the Associate Director of Behavioral Health.

Post-service decisions are determinations of medical necessity and/or appropriate level of care when the care has already been received, for example, retrospective review. Notification of post-service decision denial determinations is given electronically or in written form to the practitioner and member within 30 calendar days of the request. For example, a claim received for out-of-area care that was not prior authorized.
All potential post-service denial decisions based on medical necessity or appropriate level of care are reviewed by the Medical Director and a determination is made by him, or his designee.

Members may be selected for Behavioral Health Case Management based on criteria that address various demographics, including but not limited to: age, psycho-social and economic status, support systems, diagnoses, complexity of treatment plan.

Cases may be identified through utilization reports, health promotion activities, claim activity reports, complicated inpatient admissions and practitioner, provider or member pre-service authorization. Case Management is conducted in collaboration with the physician, supports the physician/member relationship, and promotes adherence to an established treatment plan. Members are notified of their selection for case management.

SECTION 20: CHIROPRACTIC CARE MANAGEMENT

Chiropractors have limited access to specialty imaging services and laboratory testing with appropriate authorization. Arise Health Plan chiropractic services are monitored and reviewed by the Director of Chiropractic Services. The Director of Chiropractic Services works collaboratively with the Medical Director and Medical Management in accordance with appropriate state statute and is able to make chiropractic clinical management decisions autonomously. Arise Health Plan chiropractors are encouraged to collaborate directly with primary care and specialty medical services to facilitate the most cost-effective and expeditious authorizations within the network.

The Chiropractic Care Management Program will make pre-service or post-service authorization determinations of all services from non-participating practitioners. These services will be reviewed for medical necessity and/or coordination of care/services.

- Requests can be submitted by facsimile, telephone, or mail.
- All data and relevant information is obtained, including but not limited to, medical records and communications with practitioner or other consultants.
- Relevant information is reviewed using utilization management criteria as described in resources/tools section.
- Determinations for non-urgent pre-service approval decisions are given to the practitioner and member via oral, written, or electronic notification within 15 calendar days of the request. Determinations for non-certifications (denials) in this category (non-urgent) are given within 15 calendar days of the request via oral, written or electronic notification.
- Determinations for urgent pre-service approval decisions are given to the practitioner and member via oral, written, or electronic notification within 72 hours of the request. Determinations for non-certification (denials) in this category (urgent) are given within 72 hours of the request, via oral, written, or electronic notification.
- Pre-service approval decision letters for chiropractic services are sent to the member and to the practitioner who is providing the requested services.
- Requests to extend a course of treatment previously approved that does not meet the definition of urgent care will be handled as a new request, and the appropriate timeframes followed.
- All potential denial decisions based on medical necessity related to concurrent review are reviewed by the Director of Chiropractic Services and a determination made by him or his designee.

All written denial determination notification includes:

- The specific reason for the denial.
- A reference to benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.

SECTION 20: CHIROPRACTIC CARE MANAGEMENT

- An offer to provide a copy of the actual benefit provision, guideline, diagnosis/treatment codes, protocol, or other similar criterion on which the denial decision was based, upon request.
- A description of appeal/grievance rights, including the right to submit written comments, documentations, or other information relevant to the appeal/grievance.
- An explanation of the appeal/grievance process including the right to member representation and timeframes for deciding appeals/grievances.
- Notice of the External Review Process, if applicable.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care and ongoing treatment.

Post-service decisions are determinations of medical necessity and/or appropriate level of care when the care has already been received, for example, retrospective review.

Notification of post-service decision denial determinations is given electronically or in writing to the practitioner and member within 30 calendar days of the request.

SECTION 21: PHARMACY MANAGEMENT

Arise Health Plan offers a comprehensive prescription drug program, including a suitable array of products, to allow practitioners to appropriately manage their patients.

Program leadership is provided by Arise Health Plan's Director of Pharmacy and Medical Director who work in conjunction with plan practitioners.

Arise Health Plan's Pharmacy Program is overseen by the Quality Improvement Committee and is administered by Express Scripts.

The Pharmacy Management Program is reviewed at least annually and updated as needed. Changes to the program are communicated to practitioners via direct mail, e-mail, and/or the Internet.

SECTION 22: PHARMACY BENEFITS OVERVIEW

Arise Health Plan contracts with Express Scripts to process pharmacy claims and to issue drug benefit I.D. cards. Express Scripts is also Arise Health Plan's exclusive provider of mail order pharmacy services.

Please Note: Not all members receive their drug benefits through Arise Health Plan. Please verify drug benefits by checking the member's pharmacy I.D. card.

Arise Health Plan uses a formulary designed and maintained by Express Scripts. It can be accessed via the Arise Health Plan website. A formulary is a list of drugs that can be used by practitioners to identify drugs that offer the greatest overall value. It does not guarantee coverage and should be only used as a guide.

Sometimes a prescription will not process at the pharmacy. Following is a list of common reasons. For a specific situation, please contact Member Services at (920) 490-6900 or toll free (888) 711-1444.

- A limited number of formulary drugs must meet specific criteria for use before they will be considered a covered benefit. The practitioner may be required to convey to Express Scripts certain medical information to request prior authorization. This can be done by calling 1-800-417-8164. The practitioner's office will then be notified as to whether or not the drug authorization is approved.

- If a drug prior authorization request has not been requested, or the authorization has been denied, the pharmacy will not be able to file the drug claim under the member's prescription benefit, and the member will be responsible for the entire cost of the prescription.

- Some drugs are not taken every day, for example, migraine medications. Therefore, the amount per copay is limited to what would typically be needed for that condition. If the pharmacy is submitting a quantity larger that what is allowed, the prescription will not process.

- Retail pharmacies are only able to dispense up to a continuous 30-day supply of medication. The prescription will not process if the pharmacy is trying to dispense greater than this amount.

Member Responsibility Determination
Most members have a 3-tier drug benefit. The copay/coinsurance levels vary based upon the formulary status of the drug prescribed.

- Generic drugs are on the formulary and carry the lowest responsibility (1st tier)
- Brand name drugs that are on the formulary are the middle responsibility (2nd tier)
- Brand name drugs that are <u>not</u> on the formulary carry the highest responsibility (3rd tier)

  Note: Sometimes plans have a 4th tier that is unique for specialty drugs. High Deductible Plans have a combined medical and pharmacy benefit which does not incorporate a tiered benefit.

SECTION 22: PHARMACY BENEFITS OVERVIEW

Covered Drugs

Generally, covered under the prescription drug benefit are FDA-approved drugs that, by law, require a prescription from a licensed practitioner.

The only exceptions are insulin and disposable diabetic supplies-which, by law, may not require a prescription. However, to be eligible for coverage, Arise Health Plan requires that they must be medically necessary and a prescription must be written.

Commonly Excluded Drugs

- Drugs to treat toenail or fingernail fungus
- Drugs used for fertility or whose primary use is fertility
- Compounded medications that do not contain at lease one legend ingredient
- Non-Legend drugs (those available without a prescription)
- Investigational drugs
- Drugs from non-participating pharmacies, except for emergencies outside of the geographical service area.
- Replacement medications resulting from loss, theft, or damage.
- Any drug used for weight control
- Any drug used for cosmetic purposes or whose use is not medically necessary
- Any specialty compounded hormone prescription
- A covered drug related to a non-covered medical encounter
- Anabolic steroids, unless pre-service authorization is obtained.
- Any medical supply not noted elsewhere
- Injectable medications except as determined by Arise Health Plan or its designee
- Drugs used for impotence, or whose primary use is impotence, or to enhance sexual activity

Member Given Generic Drug When Brand Name Prescribed

When an FDA-approved generic to a brand name drug is available, Arise Health Plan may limit coverage to the generic form of a drug. The active ingredient(s) in a generic drug are chemically identical to their brand name counterparts. Pharmacists will dispense the generic medication in this situation. If the member requests the brand, they will be responsible for the appropriate copay/coinsurance plus the difference in cost between the brand and the generic.

SECTION 23: DRUG PRE-AUTHORIZATION

How to Request Drug Prior Authorization

The drug formulary can be viewed at: **www.WeCareForWisconsin.com**
Drugs that require authorization or have some other type of restriction are noted.

- Providers or their staff should call Express Scripts at 800-417-8464 to request a pharmacy prior authorization.
  - This line is staffed 24/7 including holidays.

- When calling, please have available the patient's Arise Health Plan ID number (from his/her card), date of birth, and access to the medical record.
  - You will be asked questions related to diagnosis, medication history, and other relevant clinical information.

- The provider's office should contact the member regarding the decision.

SECTION 24: TECHNOLOGY & INCENTIVES

Technology Assessment

Arise Health Plan has a policy that establishes procedures for the assessment of new technologies and new applications of existing technologies, including but not limited to: medical and surgical procedures, pharmaceuticals, and devices. Arise Health Plan has procedures and criteria for the submission and selection of a technology to be considered. The roles of the Medical Policy Committee, Quality Improvement Committee, and Benefits Committee are defined to address whether or not the technology will be incorporated as an Arise Health Plan benefit.

Affirmative Statement on Incentives

Utilization management decision-making at Arise Health Plan is based only on appropriateness of care, and existence of coverage. Arise Health Plan does not specifically reward practitioners or other individuals for issuing denials of coverage or service. No financial incentive is given to encourage decisions that result in under-utilization.

SECTION 25: RESOURCES / TOOLS

Utilization Review Criteria

Medical necessity decision-making requires the consistent application of utilization criteria. Arise Health Plan uses both nationally published and locally developed criteria. Input from Arise Health Plan practitioners, including department chairs and other practitioners, is solicited. The Medical Policy Committee reviews criteria for appropriateness and makes recommendations for approval to the Quality Improvement Committee. The Quality Improvement Committee makes the final decision to approve criteria for use. Decision making criteria is reviewed and updated annually or more frequently if significant changes in standards of care are identified.

Criteria are applied consistently to medical necessity decisions, and in a manner that is responsive to individual member needs and the characteristics of the local delivery system. At least annually, Arise Health Plan evaluates the consistency with which Case Management Specialists and the Medical Director apply the criteria when making decisions. A corrective action plan is developed if significant variation is found.

The following criteria used by Arise Health Plan are, but not limited to:

- Milliman Care Guidelines, for Inpatient and Surgical Care, Ambulatory Care (Medical and Behavioral health and Chiropractic Care), General Recovery and Chronic Care
- Hayes Medical Technology Directory
- Mercy Conference Guidelines, Cochraine Collaborative Systemic Reviews and CCGPP for Low Back Pain (for Chiropractic Care)
- DSM-V Criteria (Behavioral Health)
- Medical Policy Committee Decisions (Coverage Policy Bulletins)
- Pharmacy Benefit Criteria (includes clinical data, reference materials, expert physician opinion, FDA-approved labeling, and/or cost-benefit information)
- APTA Guide to Physical Therapy Practice
- Apollo Managed Care Guidelines
- National Comprehensive Cancer Network (NCCN)
- National Guideline Clearinghouse produced by the Agency for Healthcare Research and Quality (AHRQ)

Arise Health Plan practitioners/providers may review Medical Management criteria. If requested, a copy of specific criteria used for decision-making is provided to an Arise Health Plan practitioner. This copy is for the practitioner's own use, and may not be released to others without permission from the Arise Health Plan. Arise Health Plan practitioners are informed of the process to request criteria during practitioner orientation and the provider newsletter.

The Medical Director, or designee attempts to contact the attending practitioner prior to making an inpatient medical necessity denial. The Medical Director's phone number is provided to the ordering practitioner when a medical necessity denial is made for outpatient care.

SECTION 25: RESOURCES / TOOLS

Policies/Procedures

Policies are statements that define how Arise Health Plan intends to administer its Medical Management program. Medical Management policies are presented to the Quality Improvement Committee for review. Each department is responsible for development of procedures for functions within its responsibility.

Clinical Experts

In addition to the Medical Director, Medical Management has access to clinical experts through Arise Health Plan's practitioner panel, many of whom participate on various committees at Arise Health Plan and are board certified. Arise Health Plan also purchases a variety of expert services through external vendors. Examples of expert vendors used are:

- ALLMED
- Medical Review Institute of America
- National Medical Review, Inc.

External Review

The Medical Director, or designee, consults with board-certified practitioners when appropriate, to accommodate the medical necessity review process. Access is also provided to external review agencies that employ board-certified practitioners for case review.

Clinical Practice Guidelines

Clinical Practice Guidelines are designed to assist physicians 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.

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.

As a condition of accreditation, The National Committee for Quality Assurance (NCQA), which is the accrediting organization for managed care plans, requires the adoption of Clinical Practice Guidelines. In addition, guidelines are helpful in demonstrating the quality of care we provide to those who purchase our services.

Clinical Practice Guidelines adopted by Arise Health Plan may easily be accessed by visiting the Arise Health Plan web site at www.WeCareForWisconsin.com and clicking the Policies tab. Another valuable resource for accessing nationally recognized and supported Clinical Practice Guidelines is the National Guideline Clearinghouse produced by the Agency for Healthcare Research and Quality (AHRQ). This site is available at www.guideline.gov/index.aspx.

SECTION 26: MEDICAL POLICY GUIDELINES

Practitioners and other providers may obtain the medical policy guidelines used for making medical coverage determinations for an Arise Health Plan member under their care. Our medical policy guidelines are based on sound medical and clinical evidence and adopted with the involvement of appropriate medical specialists.
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
Attn: Medical Management Department
P.O. Box 11625
Green Bay, WI 54307-1625

Phone: (920) 490-6901 or toll free (888) 711-1444, Ext. 6901
Fax: (920) 490-6943

Note: 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. By following the medical policy guidelines, payment of health insurance benefits is not guaranteed.

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.

If you have comments or suggestions regarding any specific guideline, you may forward them in writing to:

Arise Health Plan
Attn: Medical Management Department
P.O. Box 11625
Green Bay, WI 54307-1625

SECTION 27: QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program is the framework for Arise Health Plan's processes and continuous monitoring of our performance according to, or in comparison with, objective, measurable performance standards. The Quality Improvement Program assures identification and evaluation of issues that impact our ability to continually better our performance and improve the health care and administrative services provided to our customers.

The scope of the Quality Improvement Program includes all aspects of services provided by health plan practitioners, providers, and staff. Arise Health Plan arranges for the provision of comprehensive health care delivery through a network of primary care and specialty practitioners, behavioral health practitioners and clinicians, ancillary care providers, hospitals, and other health care facilities. The scope of the Quality Improvement Program encompasses all care delivered by these practitioners and providers. All Arise Health Plan departments participate in the Quality Improvement Program. All components of the process are interrelated. The review and evaluation of the components shall be directed by the Quality Improvement Committee and is initiated at the end of each calendar year.

The scope of the Quality Improvement Program incorporates components as outlined below. A description of each aspect is found in the Program Components section that follows:

- Regulatory and professional compliance
- Credentialing and recredentialing
- Medical management
- Behavioral health care
- Disease management
- Pharmacy management
- Quality of care and service
- Member diversity
- Patient safety

Arise Health Plan is dedicated to delivering high quality services to members. The following goals are major areas of focus or priority.

The objectives include the major plan-wide initiatives that will be undertaken to ensure achievement of the goal. Our guiding principle is to provide services with the following characteristics outlined by the Institute of Medicine:

- safe
- timely
- effective
- efficient
- patient/member-centered
- and equitable

SECTION 27: QUALITY IMPROVEMENT PROGRAM

Goal A: Structure

Goal Statement: The structure and resources needed to achieve the goals of the Quality Improvement (QI) Program are reviewed at least annually through the Quality Improvement Committee.

Objectives:

- Monitor Quality Improvement Program yearly to assess progress and resource allocation
- Complete year-end evaluation of the Quality Improvement Program and Plan
- Develop annual work plan
- Review and revise Quality Improvement Program Description
- Evaluate effectiveness of delegated activities
- Maintain organizational decision-making structure
- Support the organizational data dashboard
- Oversee process improvement teams

Goal B: Clinical Outcomes

Goal Statement: Clinical quality and outcomes will exceed regionally and/or nationally established standards.

Objectives:

- Attain or maintain HEDIS® scores at or above the 90th National Percentile of the Quality Compass.
- Attain NCQA accreditation at an excellent rating.
- Maintain system-wide disease management initiatives for diabetes, heart failure coronary artery disease.
- Adopt and disseminate new clinical practice guidelines as appropriate and review those in existence.
- Promote preventive care guidelines to improve HEDIS® effectiveness of care measures such as cervical, breast and colorectal cancer screenings
- Implement interventions to improve HEDIS® effectiveness of care measures.
- Participate with the Fox Valley Area Asthma Coalition to promote the clinical practice guideline and improve the asthma HEDIS® measure
- Participate with the Wisconsin Diabetes Advisory Group to promote the clinical practice guideline and improve the diabetes HEDIS® measures.
- Participate with the Wisconsin Association of Health Plans Quality Management Committee.
- Support member wellness through the development of a Wellness/Prevention Program, which includes: member-specific reminders for needed care or missed services, information about evidence based care guidelines and diagnostic and treatment options, self management tools, information about community based resources and affinity programs.
- Encourage groups to provide incentives to members for completing a Health Risk Appraisal (HRA), access guideline appropriate care or use disease-specific web-based tools.

- Further develop the HRA tool (in accordance to NCQA specifications) to support members and employers in achieving their health and wellness goals.
- Support the plan's medical groups in developing the "Patient Center Medical Home" concept of caring for our members.
- Analyze and address the existence of significant health care disparities in clinical areas
- Maintain the case management team to serve members with complex health needs.

Goal C: Customer Service Outcomes

Goal Statement: Customers will experience excellent and compassionate service.

Objectives:

- Attain or maintain CAHPS® scores at or above the 90th National Percentile of the Quality Compass.
- Analyze CAHPS® survey results annually and target improvement initiatives for low scoring areas.
- Analyze member complaints and grievances semi-annually and initiate improvements as needed.
- Analyze Member Service and telephone access indicators semi-annually.
- Use the Arise Rapid Improvement and System Evaluation methodology to develop or improve system process as needed.
- Conduct annual Practitioner Satisfaction Survey regarding Utilization Management processes and implement improvements as indicated.
- Survey key leaders of provider networks regarding acceptance of clinical criteria for UM decisions.
- Maintain a web site offering Health Risk Appraisal (HRAs) and Self Management Tools.
- Enhance the secure customer web-portal to improve access to claims/benefit information.
- Continue Health Literacy initiatives to improve customer understanding and satisfaction with services provided.
- Continue the Living Well with Chronic Disease Program for targeted members.
- Evaluate the need for culturally competent communication and provide information, training and tools as needed.

Clinical Practice Guidelines

Arise Health Plan uses clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances.

Currently fourteen clinical practice guidelines for acute and chronic medical care have been adopted, two of which relate to behavioral health. Four of the adopted clinical practice guidelines are the basis for Disease Management programs which are managed by StayWell Health Management, an NCQA certified vendor of disease

management programs. In addition, there are two guidelines for general preventative health services, adult and pediatric. The selected guidelines are from nationally recognized organizations using evidence-based outcomes:

- Adult depression in primary care
- Adult preventive care
- Asthma
- Attention deficit hyperactivity disorder
- Controlling blood pressure
- Diabetes mellitus
- Diagnosis and management of chronic heart failure in the adult
- Diagnosis and treatment of low back pain
- Diagnosis and treatment of stable chronic obstructive pulmonary disease
- Healthy lifestyles
- Pediatric preventive care
- Prevention, assessment and treatment of child and adolescent overweight and obesity
- Secondary prevention for patients with coronary and other atherosclerotic vascular disease
- Prenatal Care

The Quality Improvement Committee or its designee is responsible for distribution of approved clinical practice guidelines to the appropriate practitioners. Distribution is done via the internet. Written notification of the availability of the information on the Web is mailed to all participating practitioners. A paper copy of the clinical practice guidelines posted on the Web is available upon request.

Disease Management

Arise Health Plan realizes extra time and care is required in treating your patients who have, or are at risk for diabetes, coronary artery disease or heart failure. To support the care you provide your patients and assist you in better managing your time, Arise Health Plan contracts with StayWell Health Management. to provide coordinated chronic disease management services to eligible Arise Health Plan members. The StayWell program encourages the appropriate use of prescribed medications and educates patients to help them make healthy decisions between office visits, with the intent of reducing serious complications and the need for additional Emergency Department visits and hospitalizations.

You will be notified if one of your higher risk patients, actively enrolled in the program, has a change in their condition. In addition, you will receive regular quarterly reports on your actively enrolled patients. Other program features include health promotion activities, health education programs, and the monitoring of vital signs and symptoms to help avoid preventable hospitalizations.

SECTION 28: URGENT CARE & EMERGENCY CARE

Urgent Care

Care received for an illness or injury with symptoms of sudden or recent onset that require medical care the same day.

Examples of urgent care situations include but are not limited to: sprained ankle, minor cut, minor burn, and children with fever. In these situations, the member should contact their PCP. During business hours, services for urgent situations should be received in the PCP's office whenever possible. For after hour services, the PCP's office should be contacted for assistance.

Emergency Care

A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the person's health, or with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child
- Serious impairment to the person's bodily functions
- Serious dysfunction of one or more of the person's body organs or parts

Examples of emergency conditions include but are not limited to:

- Loss of consciousness
- Severe burns
- Heavy bleeding
- Possible heart attack

For emergency conditions in our service area, access the closest in-network hospital emergency facility. When out of our service area, access the closest hospital emergency facility. Follow-up care should be arranged through your PCP.

Emergency Room and Urgent Care Coverage

In the event of a medical emergency, hospital care is covered wherever it is received. However, if a member is admitted, a participating PCP must be notified within 48 hours of being medically able.

When urgent care is needed for a non-life threatening illness or injury, members should contact their PCP prior to seeking care for direction to the appropriate medical facility.

Arise Health Plan provides, arranges for, or otherwise facilitates, needed emergency services or instructs the members to call 911.

Arise Health Plan will not deny coverage for emergency services for a member without prior authorization when:

- Such care is received to screen and stabilize the member where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
- An authorized representative, acting for the organization, has authorized the provision of emergency services.

SECTION 28: URGENT CARE & EMERGENCY CARE

Arise Health Plan will provide coverage for emergency services rendered during the treatment of an emergency medical condition by a non-participating provider as though the services were provided by a participating provider. Arise Health Plan will also provide coverage if the enrollee cannot reasonably reach a participating provider, or as a result of the emergency, is admitted for inpatient care subject to any restriction which may govern payment to a participating provider for emergency services.

Arise Health Plan shall pay the non-participating provider at the rate the insurer pays a participating provider after applying any copayments, coinsurance, deductibles, or other cost-sharing provisions that apply to participating providers.

Emergency Room and Urgent Care Coverage – College Students

- In the event of a medical emergency, the member is covered regardless of where medical care is received.
- After receiving emergency care, the member must call their PCP or Arise Health Plan's Member Services' staff on the following business day or when they are able. Member Services' toll-free number is (888) 711-1444.
- If the member is admitted to the hospital, the member must call Member Services the next business day.
- If the member is away at college and an acute medical problem develops, the member should call their PCP first. If the PCP cannot handle the member's problem, he or she will refer you to the college's health center, a local physician's office, or an urgent care center.
- If additional services are needed, the member will need a pre-service authorization from their PCP and approval from Arise Health Plan's Medical Director. The member may need to return home to receive treatment from a participating provider.
- If the member requires ongoing medical care, the member will need a pre-service authorization from their PCP and approval from Arise Health Plan's Medical Director.
- Some out-of-area medical facilities, not in Arise Health Plan's participating provider network, may require the member to pay for their care at the time it is given. To arrange for reimbursement, send itemized bills and proof of payment within 90 days to:

  Claims Department
  Arise Health Plan
  P.O. Box 11625
  Green Bay, WI 54307-1625

- The member will be responsible for out of area charges that exceed usual and customary charges.
- Routine care should be received from a participating PCP when the member is in Arise Health Plan's service area.

If the member has additional questions, please contact Member Services at (920) 490-6900 or toll free (888) 711-1444.

SECTION 29: MEMBER RIGHTS & RESPONSIBILITIES

The Member Rights and Responsibilities listed below set the framework for cooperation among covered persons, practitioners and Arise Health Plan.

Member Rights as a Health Plan Member

You have the right to be treated with respect and recognition of your dignity and right to privacy.

You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

You have the right to participate with practitioners in making decisions about your health care.

You have the right to receive information about us, our services, our network of health care practitioners and providers, and your rights and responsibilities.

You have the right to voice complaints or appeals about us or the care we provide.

You have the right to make recommendations regarding the members' rights and responsibilities policies.

Member Responsibilities as a Health Plan Member

You have the responsibility to supply information (to the extent possible) that we and our practitioners and providers need in order to provide care.

You have the responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

You have the responsibility to follow the treatment plan and instructions for care that have been agreed on with your practitioners.

SECTION 29: MEMBER RIGHTS & RESPONSIBILITIES

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Protected Health Information

Arise Health Plan uses and discloses health information about members for payment and health care operations, and for their treatment. Health care operations, includes efforts to track our Quality Improvement activities.

Members may give us written authorization to use their health information, or to disclose it to anyone, including themselves, for any purpose. If members give us an authorization, they may revoke it at any time. We may disclose a member's health information to a family member, friend, or other person to the extent necessary to help with their health care or with payment for their health care. In the event of a member's incapacity or an emergency, we will disclose their health information based on our professional judgment of whether the disclosure would be in their best interest.

Members have the right to look at or get copies of their health information, with limited exceptions. Please visit our Web site or contact the number listed at the end of this notice for further information.

We are committed to protecting the confidentiality and privacy of every aspect of service and care across the organization. We have developed, implemented, maintained, and used appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information and to prevent intentional or unintentional use or disclosure in violation of law.

We may disclose summary information about the participants in a member's group health plan to the plan sponsor in order to obtain premium bids for health insurance coverage. This summary information is stripped of any personal information and contains only general statistics about the types and costs of claims.

If you want more information about our privacy practices, or have questions or concerns, visit our Web site at www.WeCareForWisconsin.com, or call our Privacy Official at (920) 490-6900 or toll free at (888) 711-1444.

SECTION 30: MEMBER GRIEVANCE PROCEDURES

This section includes the appeal rights and the grievance procedure for covered persons of plans that are governed by the Employee Retirement Income Security Act of 1974 (ERISA). Members of ERISA plans have the right to file a civil action under Section 502 (a) of ERISA if a health plan fails to establish or follow claims procedures, or after all appeals outlined in this section have been completed.

A grievance is any dissatisfaction with the administration, claims practices, or provision of services by Arise Health Plan that is expressed in writing to Arise Health Plan, by or on behalf of, a covered person.

A Grievance Committee is convened every other Tuesday to review all grievances.

The Grievance Committee is comprised of Arise Health Plan representatives, including a clinical representative, and an enrollee.

Any covered person who files a grievance will be notified of their right to appear in person before the Grievance Committee. The covered person, or their authorized representative, may present written or oral information and ask any questions relating to the grievance. Arise Health Plan will send the covered person written notice of the time and place the covered person may appear before the Grievance Committee at least seven calendar days prior to the appearance date. Following a thorough review of the case, the grievance committee votes on the resolution. A resolution letter is sent within ten calendar days.

Grievances are resolved within 30 calendar days, unless the covered person gives permission for a 30-day extension. If the person's medical condition warrants, the grievance may be expedited and resolved within 72 hours.

Independent Review

The covered person, or their authorized representative, may request and obtain an independent review of an adverse determination or an experimental treatment determination. Please call Member Services Department at (920) 490-6900 or toll free (888) 711-1444 for more information.

Reconsiderations

In addition, a practitioner has the opportunity to appeal an adverse determination (denial) by submitting any additional information orally and/or in writing with a request for reconsideration.

SECTION 31: CLAIM PAYMENT POLICIES

Arise Health Plan - Paper Claims Submission Address:

Arise Health Plan
P.O. Box 981649
El Paso, TX 79998-1649

Phone Number: (920) 490-6900 or toll free (888) 711-1444
Fax Number: (920) 490-6921

Arise Health Plan Electronic Submission Information

ARISE electronic claims should be submitted directly to WPS Health Insurance (WPSHI) using a secure FTP process (WPS Secure EDI) or the WPS Bulletin Board System (BBS). If you currently send your ARISE claims to ClaimsNet clearinghouse, you may continue to do this and ClaimsNet will forward them to WPS.

If you will be submitting your claims through an existing WPS EDI Trading Partner (i.e. clearinghouse) who has an established Submitter ID on our WPS Trading Partner System, you may continue to use the same Submitter ID for Arise business or you may elect to receive a new Submitter ID. If you prefer to submit EDI claims directly to WPS (without using a clearinghouse) you will need to complete a self-registration process on the WPS Trading Partner System (WTPS) to prepare for transaction testing and production claim submission. WTPS is located at the following URL: https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do.

Providers will be required to complete an EDI enrollment agreement prior to submission of ARISE EDI transactions to WPS. If you have elected to use a clearinghouse to submit your claims, you will still need to complete the EDI provider agreement. Once we have processed your agreement, we will contact you and your clearinghouse (if this is a chosen option) with approval to begin submitting test or production files. It is normally not required to test when submitting through an approved clearinghouse. The agreement can be found on the WPS EDI web site at: http://www.wpsic.com/edi/tools.shtml.

If you have any questions, please contact the WPS Health Insurance EDI Marketing staff at 1-800-782-2680, option 4 or simply **email us at EDI@wpsic.com**. You may also **contact the EDI help desk at 1-800-782-2680, Option 2** for additional assistance.

iCES®

To ensure consistency of our claims payment process, Arise Health plan utilizes OptumInsight's iCES® claim editing software. The edit rationales is derived from national standards, including but not limited to CCI, CPT, AMA, CMS or other professional organization recommendations.

Arise Health Plan also utilizes a web-based application that discloses the health plan's payment policies for various code combinations. The application can either be used

proactively or retrospectively by provider offices to understand the clinical rationale supporting a particular edit.

This web application is available to all contracted providers through www.WeCareForWisconsin.com web site.

- From the home page, under "Providers", select Claim Editing
- You will be prompted to enter your "user name" and "password". Fill in your tax identification number in each field. Then select "log in".

- You will need to accept the "terms and conditions of use" before accessing the home page.

The application is designed to make our claims' payment policies, related rules, clinical edit clarifications, and clinical sourcing information easily accessible and transparent for Arise Health Plan providers.

iCES® will be updated by Arise Health Plan when appropriate. Accordingly, please note that the results reflect the payment policies on the current date, not necessarily the service date.

If you need training or assistance, support is available through our Network Management Department. Please email GBNetworkDevelopmentDept@arisehealthplan.com.

iCES® is a trademark of OptumInsight, an independent contractor.

Hospital Bill Audit

HealthDataInsights™

Arise Health Plan uses HealthDataInsights™ (HDI) to perform on-site audits of large hospital bills. HDI has signed a Business Associate Agreement with Arise Health Plan to comply with appropriate HIPAA privacy requirements. The primary focus of HDI is to audit hospital inpatient bills for potential errors, and to work with hospitals to:

- issue any refunds due to Arise Health Plan from these audits.
- identify charges that were not previously billed to Arise Health Plan, which can result in adjustments.

Modifiers

For processing claims for contracted providers Arise follows industry standards relating to standard billing modifiers and coding similar to those established in UB-04 and CMS's Medicare Database.

Below is a listing of the most commonly billed modifiers with reimbursement impact and Arise's Reimbursement Policies. The rates noted apply to our standard business. Self insured groups retain the right to apply different percentages based on these modifiers. If you have a question on a modifier not listed below, please contact our Network Development Department.

SECTION 31: CLAIM PAYMENT POLICIES

Term definition

Allowed Amount means the maximum rate allowed for the health care services according to the fee schedule.

Modifier	Description	Adjustment Rate
Modifier 22	Increased Procedural Services	Maximum of 110% of Fee Schedule Allowan Contracted Rate with supporting documenta
Modifier 26	Professional Component	Professional Fee Schedule Allowance/ Contracted Rate
Modifier 33	Preventative Service	Informational modifier only. No additional reimbursement
Modifier 50	Bilateral Procedure	150% of Fee Schedule Allowance/ Contracted Rate. **Submit one line with one unit**
Modifier 51	Multiple Procedure	50% of Fee Schedule Allowances/Contracted Rate for each additional procedure unless procedure is exempt from multiple procedure logic
Modifier 52	Reduced Services	50% of Fee Schedule Allowance/Contracted Rate
Modifier 53	Discontinued Procedure	50% of Fee Schedule Allowance/Contracted Rate
Modifier 54	Surgical Procedure Only	70% of Fee Schedule Allowance/Contracted Rate
Modifier 55	Follow up Care Only	20% of Fee Schedule Allowance/Contracted Rate
Modifier 56	Preoperative management	10% of Fee Schedule Allowance/Contracted Rate
Modifier 62	Co-Surgeons (Two Surgeons)	125% of Fee Schedule Allowance/Contracted Rate divided by 2 for each surgeon 62.5% each
Modifier 80/AS	Assistant Surgeon	20% of Fee Schedule Allowance/Contracted Rate for MD 10% of Fee Schedule Allowance/Contracted Rate for PA
Modifier 81	Minimum Assistant Surgeon	20% of Fee Schedule Allowance/Contracted Rate for MD 10% of Fee Schedule Allowance/Contracted Rate for PA
Modifier 82	Assistant Surgeon w/o Resident	25% of Fee Schedule Allowance/Contracted Rate for MD 10% of Fee Schedule Allowance/Contracted Rate for PA
Modifier SG	Surgery Center Primary	100% of Fee Schedule Allowance/Contracted Rate

Modifier SG-51	Surgery Center Secondary	50% of Fee Schedule Allowance/Contracted Rate
Modifier TC	Technical	Fee Schedule Allowance/Contracted Rate
Anesthesia	**All general anesthesia surgical services should be billed with the appropriate CPT code ranges for anesthesia services 00100- 01999 to ensure appropriate reimbursement**	**Qualifying circumstances should be billed with the appropriate CPT code**
Anesthesia Modifiers	**Description**	**Adjustment Rate**
Modifier AA	Administered by anesthesiologist	100% of Fee Schedule Allowance/Contracted Rate
Modifier AD	Medical supervision more then four concurrent anesthesia procedures	50% of Fee Schedule Allowance/Contracted Rate
Modifier QK	Medical direction of two three or four concurrent anesthesia procedures involving qualified individuals	50% of Fee Schedule Allowance/Contracted Rate
Modifier QS	Monitored anesthesia care services	100% of Fee Schedule Allowance/Contracted Rate
Modifier QX	Administered by CRNA with medical direction	50% of Fee Schedule Allowance/Contracted Rate
Modifier QY	Medical direction of CRNA by anesthesiologist	50% of Fee Schedule Allowance/Contracted Rate
Modifier QZ	Administered by CRNA without medical direction	100% of Fee Schedule Allowance/Contracted Rate
Physical Status Modifiers (Anesthesia)	**Description**	**Adjustment Rate**
Modifier P1	A normal healthy patient	No Additional Units Allowed
Modifier P2	A patient with mild systemic disease	No Additional Units Allowed

Modifier P3	A patient with severe systemic disease	One additional unit
Modifier P4	A patient with severe systemic disease that is a constant threat to life	Two additional units
Modifier P5	A morbid patient who is not expected to survive without the operation	Three additional units
Modifier P6	A declared brain dead patient whose organs are being removed	No Additional Units Allowed
DME	**Description**	**Adjustment Rate**
NU	Purchased DME	Fee Schedule Allowance/Contracted Rate
RR	Rental DME	Fee Schedule Allowance/Contracted Rate

- Always submit the full billed amount. Arise will apply the reimbursement methodology listed above.
- Reimbursement based on AWP will utilize the MediSpan data or subsequent replacement of First Data Bank and Redbook sources.

Multiple Endoscopies
Reimbursement for multiple endoscopies will be made by Arise Health Plan using the following methods:

Billed Charges Reimbursement:

- 100% of the contracted fee for the procedure listed with the highest value (primary procedure).
- 10% of the contracted fee for multiple endoscopies beyond the primary procedure.

Fee Schedule Reimbursement:

- 100% of the fee schedule amount for the most costly endoscopy CPT (based on the fee schedule, not the billed amount).
- For each less costly endoscopy CPT, reimbursement will be calculated by:
  - Taking the fee schedule amount for each less costly endoscopy less the fee schedule amount of the base code for the corresponding endoscopy family.

SECTION 32: PROVIDER CREDENTIALING, RE-CREDENTIALING & UPDATES

Credentialing/Re-Credentialing

Arise Health Plan has its own internal Credentialing Department. This department is responsible for the processing of initial and recredentialing practitioner/provider applications. New/renewed licensures, malpractice insurance, DEA, and other pertinent certifications are submitted to this department.

Arise Health Plan credentials practitioners who have an independent relationship with us. An independent relationship exists when Arise Health Plan selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners whom can be selected as PCP's.

Arise Health Plan conducts a pre-contractual assessment (initial credentialing) and an ongoing assessment (recredentialing), thereafter, at least every three years, of the following professionals:

Doctors of:

- Medicine (M.D.)
- Osteopathic Medicine (D.O.)
- Podiatric Medicine (D.P.M.)
- Chiropractic (D.C.)
- Optometry (O.D.)
- Doctors of Dental Science (D.D.S.); Doctors of Medical Dentistry (D.M.D.) who provide care under the medical benefit program.

Behavioral Health Care Practitioners Including but not Limited to:

- Psychiatrists and other physicians
- Addiction Medicine specialists
- Doctoral or Master's level Clinical Psychologists (PhD or PsyD)
- Master's level clinical nurse specialists or psychiatric nurse practitioners (NP, APNP)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Professional Counselors (LPC)
- Licensed Social Workers (APSW, ISW, LCSW),
- Substance Abuse Counselors (SAC, CSAC)
- Master's Level Counselors (MA, MS, MSE, MSW)
- Behavioral Analysts (LBA)

Allied Health Professionals Practicing in a Primary Care Area:

- Advanced Practice Nurse Prescribers (APNP)
- Family Nurse Practitioners (FNP)
- Master's Level Clinical Nurse Specialists (NP)
- Certified Nurse Midwives (CNM)
- Physician Assistants (PA or PAC)
- Audiologists (AuD)

Other **Allied Health Professionals** who have an independent relationship with us and are not part of an organization or group of practitioners.

Covering practitioners (Locum Tenens) providing services for a period of time longer than three months.

Practitioners who are hospital based, but who see members outside of the inpatient hospital setting or outside free standing, ambulatory facilities as a result of their independent relationship with the plan (Pain Medicine, Radiation Oncology)

The decision to credential or recredential a practitioner is based on the information assembled, including but not limited to the information gathered through a completed application and primary source verification. Credentialing/recredentialing criteria are used to establish consistent, clear objectives for the credentialing/recredentialing of practitioners. The credentialing/recredentialing decision to approve or deny the applicant is determined by the Credentials Committee. Arise Health Plan credentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes. This does not preclude Arise Health Plan from including in its network, practitioners who meet certain demographic or specialty needs.

Arise Health Plan conducts a pre-contractual assessment of each organizational provider with which it contracts, and an ongoing assessment at least every three years.

During the Credentialing Process:

- You may request information regarding the status of your application at any time.
- 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.
- Notification of the Credentials Committee decision regarding your application will be sent via written letter promptly after the meeting at which your application is presented.

Organizational Providers Include:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Freestanding surgical centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.

Arise Health Plan Shall Confirm that the Organizational Provider:

SECTION 32: PROVIDER CREDENTIALING, RE-CREDENTIALING & UPDATES

- Meets all state and federal licensing and regulatory requirements in good standing; and
- Has proof of adequate liability insurance; and
- Has evidence of accreditation by a recognized accrediting body or current CMS certification; or meets Arise Health Plan's standards of participation with an overall site visit score of at least 80%

Questions or Updates: Contact the Credentialing Department

Arise Health Plan
PO Box 11625
Green Bay, WI 54307-1625

Phone: 920-490-6952 or 920-490-6954
Fax: 920-490-6955 or 608-221-5479
Email: GBCredentialingDepartment@AriseHealthPlan,com

SECTION 33: CONTINUITY OF CARE

Under certain circumstances, if a covered person's PCP or specialist leaves our network, the covered person may continue to receive care from that practitioner.

We will continue to provide coverage for services from a practitioner who terminates from Arise Health Plan under the following circumstances:

- The practitioner continues to practice within the geographical service area.
- The practitioner did not terminate with the health plan due to misconduct.
- We represented that the practitioner was, or would be, participating in Arise Health Plan marketing materials available to the covered person at the time of their initial enrollment, most recent coverage renewal, or most recent open-enrollment period, whichever is later.
- If the practitioner is the covered person's PCP at the time of termination, we will continue to cover services provided by that practitioner until the end of the plan year.
- If the covered person is undergoing a course of treatment with a specialist who terminates, we will continue to cover non-maternity services from that specialist for the following period of time:
  - For the remainder of the course of treatment, or
  - For 90 days after the specialist's participation terminates, whichever is shorter.
  - Certain groups cover specialty services until the end of the current plan year for which it was represented that the specialist was, or would be participating.
- If the covered person is receiving maternity care from a practitioner other than the covered person's PCP, and the covered person is in the second or third trimester of pregnancy when the practitioners' participation terminates, we will continue to cover practitioners' services from that provider until the completion of postpartum care for the mother and infant.

Notification to Members Affected by the Termination of a Specialist or PCP

Arise Health Plan takes responsibility for notifying affected members of specialist or PCP terminations and options for receiving continued care. Notification is not done if the specialist or PCP moves outside the service area, is terminated for cause, retires, or is no longer caring for patients in the same manner of their prior practice.

Arise Health Plan offers a variety of products, including ASO, HMO, Point of Service (POS), Individual and 65+ (a Medicare Select Policy). Arise Health Plan products have various levels of co-payments, coinsurance, deductibles, and out-of-pocket maximums.

Please refer to the Member ID Card for benefit information, or contact the Arise Health Plan Member Service area for a particular member's benefits. Please keep in mind these are a general level of benefits, and not a guarantee of payment. All benefits are subject to the terms and limitations of the policy, and subject to medical necessity. The Arise Health Plan Member Service phone number is (920) 490-6900 or toll free (888) 711-1444.

SECTION 34: ARISE HEALTH PLAN PRODUCT OVERVIEW

Arise Health Plan offers a broad range of insurance and employee benefit products to meet the needs of our group and individual customers, from traditional HMO and POS plans and self-funded administration, to consumer-driven options.

Arise Health Plan – Fully Insured (Risk Business)

Group Plans
Arise Health Plan offers a wide variety of group products proving exceptional flexibility for employer groups. Employers can choose from Point of Service (POS) plans, Health Maintenance Organization (HMO) plans as well as consumer-driven options that include Health Savings Account (HSA) – qualified high-deductible health plans.

Individual Plans
Arise Health Plan also offers a wide variety of individual products proving exceptional flexibility and value for individuals. Individuals can choose from Point of Service (POS) plans, Health Maintenance Organization (HMO) plans as well as consumer-driven options that include Health Savings Account (HSA) – qualified high-deductible health plans.

Arise Administrators – Self Funded/ Administrative Services Only (ASO)

Arise Health Plan also contracts with employers or other group entities to administer benefit plans under an ASO arrangement. Our ASO business is administered under the name Arise Administrators.

Under an ASO arrangement, an employer hires a third party like Arise Administrators to deliver employee benefit administrative services to the employer. These services typically include health claims processing, billing, and medical management. The employer bears the risk for health care expenses under an ASO plan.

What does this mean for our contracted providers? ID cards for this business will use Arise Administrators' name and logo. Claims can be remitted to the same address used for Arise Health Plan claims.

For plans administered under an ASO arrangement, no withhold will be taken if your contract includes withhold language.

Please Note: Some ASO business may require PCP pre-service authorizations and some may not. Contact Member Services at (920) 617-6363 or toll free (888) 833-4988 to verify if the member needs a pre-service authorization for any services.

SECTION 34: ARISE HEALTH PLAN PRODUCT OVERVIEW

Arise Health Plan - 65+ Medicare Select Plan

Arise Health Plan 65+ Medicare Select Plan works to supplement Medicare A and B coverage. The 65+ members are required to access Arise Health Plan's contracted network of providers for services to be eligible for payment. Such services are those that may only be partially covered by Medicare.

65+ Medicare Select Plan Claims Processing

The back of the Arise Health Plan 65+ identification card will instruct hospitals, physicians, and other providers to send claims to:

Arise Health Plan - 65+
PO Box 12487
Pensacola, FL 32573-2487

The following information should be included on the claim:

- Patient's name & address
- Patient's ID number
- DRG Code if hospital provider
- Diagnosis Code
- CPT Procedure Code
- Provider name, address & IRS number
- Amount paid by Medicare

If provider needs to check on claims submitted for payment, please call toll free (888) 803-1599.

SECTION 35: PROVIDER CONTRACTING

Non-Contracted Providers

If interested in participating, please send a letter of intent to:

Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625

Please include the following information:

- Your name and address
- The services you provide
- If you provide any unique services or treatments
- All participating doctors at your location
- If you are treating any of our existing members

Contracted Providers

Provider Changes

- Please contact Network Development at Arise Health Plan 1-888-711-1444 or email GBNetworkDevelopmentDept@AriseHealthPlan.com of any provider changes, including staff additions or terminations, and use of Locum Tenens along with timeframes.

- Note: If you leave your current practice and open or join a new practice, it is possible that your new practice does not have a contractual agreement with Arise Health Plan.

Provider/Patient Relationships

Provider may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Compliance with Program/Provider Manual

Provider agrees to participate, cooperate and comply with materials outlined in the Provider Manual, including, quality improvement activities. Provider agrees to allow Arise to use performance data, such as but not limited to WCHQ, WHIO, etc. for analysis and peer comparison. Such data may be used to develop and evaluate quality improvement activities. Results may be shared via public reporting methods and other methods, including but not limited to, web-based tools.