ARISE HEALTH PLAN
CHIROPRACTIC ADDENDUM
TO PROVIDER’S MANUAL
2014
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Welcome to Arise Health Plan!

WPS Health Plan, Inc. d/b/a Arise Health Plan (henceforth “Arise Health Plan”) is one of Wisconsin’s most rapidly expanding Health Plans. I would like to personally welcome you to the Plan. I am Kevin J. Pursel, DC, and Director of Chiropractic Services for Arise Health Plan. Arise Health Plan has, since its beginning, openly welcomed ethical, competent Chiropractors to its network of providers - welcome! Wisconsin has a competitive insurance marketplace, and Arise Health Plan has taken the lead in cost savings for employers. Additionally, Arise Health Plan has pioneered highly interactive relationships with quality conscious providers like you, to offer our members and participants - your patients - the finest services in the market. Arise Health Plan takes quality and our NCQA “Commendable” rating very seriously.

I still practice Chiropractic part-time in Green Bay and am intimately aware that participation with some “managed care” organizations means “rewards” for the participating provider of nearly insurmountable mountains of additional paperwork. Because our administrative design was edited by me, a practicing clinician, I have attempted to eliminate “unique” additional paperwork or forms from our administration. Arise Health Plan respects you and your expertise. Your new participation with Arise Health Plan is intended to cause minimal additional work to you and your staff. There are only a few changes that need to be made to your internal procedures to become completely compliant with Arise Health Plan expectations. Those changes are:

- Successful completion of the credentialing process. You are likely either in the process of or have already completed your credentialing.
- Adherence to your Participating Provider Agreement. Please review your agreement with Arise Health Plan and understand your rights and responsibilities.
- Some providers will be required to complete a Pre-Service Authorization Form at a patient’s sixth visit. This one-page form can be completed in less than five (5) minutes. It needs to be completed only if the Arise Health Plan member or participant you are treating needs care for more than six (6) total visits. The form is included in Section 4 of this Provider Manual.

Any specific questions can be answered by me directly, or I can direct you to the Arise Health Plan staff that can assist you. Please see me as a collegial point of reference within Arise Health Plan. I am glad to assist you directly. I can be reached at Arise Health Plan at (920)617-6301. I answer calls on Tuesday and Thursday mornings. Again, welcome to Arise Health Plan.

Sincerely,

Kevin J. Pursel, DC, CPC
Director of Chiropractic Services
Arise Health Plan
1B. Arise Health Plan FAQs from New Participating Providers

Do I have to fill out “Special” paperwork? Yes, some providers do. There is a Pre-Service Authorization Form to be completed for any care rendered to an Arise Health Plan Member or Participant after visit six (6) in a calendar (Jan-Dec) year. There is also a Pre-Service Authorization worksheet for MRI’s. (See Section 4 of this Provider Manual).

Do I have to “Pre-Service Authorize” Care? Yes, some providers do, but only for visits after six (6) in any calendar (Jan-Dec) year. It takes less than five (5) minutes for the average provider to complete and fax to us. An independent process for MRI Pre-Service Authorization is administrated by NIA. If you are ordering an MRI, you will need to meet their quality and Pre-Service Authorization procedures. (http://www1.radmd.com/).

What if I disagree with the reviewing chiropractor’s opinion? Decisions of the Director of Chiropractic Services are binding on you in accordance with your contract. However, to date, there have been no documented disagreements between treating in-network providers and the Director of Chiropractic Services. Although a second review of any disagreement would likely be reconsidered by a second, independent Chiropractor, that decision is at the discretion of the Director of Chiropractic Services.

I do rehabilitation in my office. Do I have to Pre-Service Authorize those services? No. It is the expectation of Arise Health Plan that you use rehabilitative services in your office. This is the standard of care for NMS conditions. Arise Health Plan recognizes and honors the entire scope of chiropractic practice in the state of Wisconsin. The only restriction is that every service you provide to our member or participant, your patient, be both legal and meet our definition of Medically Necessary. (See section 5 for our Plan Language and Definitions).

I believe in Chiropractic Maintenance care. Is that paid for by this plan? The Director of Chiropractic Services is conscious of “terminology” problems and nuance leading to misunderstanding within the chiropractic profession and the health delivery and payment communities in general. It is the position of Arise Health Plan that: Custodial or Maintenance level care is specifically excluded as a covered benefit in all Arise Health Plan designs. Elective care may be rendered by you in your office as long as a Non-Covered Services Agreement is signed by our member or participant, your patient, before these services are rendered. Once signed, you can collect directly from the patient for these elective services. Elective Chiropractic Care can be billed only as defined in section 3E. Special Coding Information of this document. Services rendered that are not defined as Medically Necessary by Arise Health Plan and absent the Non-Covered Services are not recoverable from either Arise Health Plan or our member or participant. This is in accordance with your Participating Provider Agreement. Further Medically necessary care refers to care that is generally reimbursable by third party carriers, for example, acute and/or chronic/recurrent care. Ongoing care in the chronic/recurrent population is potentially contraindicated. This is the express understanding of the CCPPP and reflects the position of Arise Health Plan. Finally, Terms such as preventative/maintenance care, defined as care to reduce the incidence or prevalence of illness, impairment, and risk factors and to promote optimal function, and supportive care, defined as treatment/care for patients having reached maximum therapeutic benefit, in whom periodic trials of therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate are also interpreted by Arise Health Plan as Maintenance, Maintenance Therapy or Custodial and are not Medically Necessary.

Is routine x-ray paid for? All Medically Necessary (See section 5 for our Plan Language and Definitions) procedures are covered by Arise Health Plan. That being said, initial, repeated, or “updated” x-rays in the absence of clinical necessity will be considered not Medically Necessary. Further, X-rays taken for our adult members or participants will need to meet the definition produced by the chiropractic profession.
What about Mechanical Traction devices like the VAX-D or DRX-9000? Currently, this procedure is considered Experimental or Investigational as defined by Arise Health Plan. (See section 5 for our Plan Language and Definitions). It is not a covered benefit by plan design. When procedures using this device meet our definition of Medically Necessary, this position will be reconsidered. The Director of Chiropractic Services makes every attempt to keep current on the scientific literature. However, if you are personally aware of valid scientific evidence to support the inclusion of not only this device but anything that is included in the Wisconsin Chiropractic scope of practice, please bring that to the attention of the Director of Chiropractic Services for Arise Health Plan.

Will Arise Health Plan limit my care in anyway? It may. Your care to our members or participants must meet our definition of Medically Necessary (See section 5 for our Plan Language and Definitions). This includes being the most cost efficient care. To date, the Director of Chiropractic Services has not reduced care to any provider within the Network, but it is possible. As Arise Health Plan moves forward with plans to institute the “Quorum” process, where payments are tied more strongly to quality reporting and less to procedures, the actual procedures you render will become less and less then ultimately unimportant.

Can I charge for services I know are not covered by Arise Health Plan? Yes, as long as a Non-Covered Services Agreement is signed by our member or participant, your patient, before these services are rendered. Once signed, you can collect directly from the patient for these elective services. Services rendered that are not defined as Medically Necessary by Arise Health Plan and absent the Non-Covered Services Agreement are not recoverable from either Arise Health Plan or the patient. This may include but is not limited to DMG’s and nutritional supplements. This is in accordance with your Participating Provider Agreement.

Where do I submit claim forms? Arise Health Plan Member and Participant ID cards contain the correct claim submission information.

How am I paid? Recent contract changes have you paid on a Fee for Services Basis in accordance with your contracted fee schedule.


Have any Chiropractors participation ever been terminated and why. Yes. Chiropractic Clinical Documentation that does not meet or exceed Chir 11.01-11.04 is the fastest way to lose your contract with Arise Health Plan (See Section 3A). If your practice style is substantially out of step statistically with our typical providers, we may also terminate your contract. If there is any concern about where you sit in the statistical mix of our typical providers, you can contact the Director of Chiropractic Services directly. Any violation of your Participating Provider Agreement would be, though to date have not been, a reason for termination.

Who do I call with questions? The best person to contact is the Director of Chiropractic Services, Kevin J. Pursel, DC. His direct line at Arise Health Plan is (920) 617-6301. He is your collegial point of reference and can either answer your question or direct you to the right person inside Arise Health Plan to answer your question.
2A. Advertising Code of Conduct

Arise Health Plan expects you to meet or exceed the requirements of Wisconsin law pertaining to advertising:

http://www.legis.state.wi.us/statutes/Stat0446.pdf
http://www.legis.state.wi.us/rsb/code/chir/chir006.pdf

Your Contract with Arise Health Plan States:

5.5.2 Approval of Marketing Use

Except as expressly permitted in Section 4.4, each party shall obtain the other party’s written permission prior to using any patented, trademarked, trade-named, service-marked or copyrighted material or property belonging to the other party. The owner shall have the right to review and approve the appearance, content, format, and/or distribution of such use.

4.4 Marketing

WPSHP may use the names, addresses, phone numbers and pictures of Providers and Credentialed Providers, identify Provider’s Services and applicable restrictions, and indicate the willingness of Provider and each Credentialed Provider to accept Members as patients in the normal course of business.

2B. Wisconsin Chiropractic Standards of Conduct

Arise Health Plan expects you to meet or exceed the requirements of Wisconsin law pertaining to Chiropractic Standards of Conduct:

http://www.legis.state.wi.us/statutes/Stat0446.pdf
http://www.legis.state.wi.us/rsb/code/chir/chir006.pdf
3A. Documentation Expectations
Arise Health Plan expects you to meet or exceed the requirements of the Wisconsin Chapter Chir 11: http://www.legis.state.wi.us/rsb/code/chir/chir011.pdf

3B. CPT Codes
This section is available by special request from the Director of Chiropractic Services for Arise Health Plan.

3C. ICD-9-CM Codes
Arise Health Plan recognizes that diagnosis is as much a clinical art as a science. Diagnoses may change during treatment. Arise Health Plan expects you to use the most appropriate ICD-9-CM Code(s) to describe our member’s or participant’s clinical presentation to your office.

3D. HCPCS Level II Codes
Arise Health Plan recognizes that sometimes HCPCS Level II Code(s) better express the interactions of you with our members and participants. Arise Health Plan expects you to use the most appropriate HCPCS Level II Code(s) to describe your interactions with our members and participants if they necessary.

3E. Special Coding Information
Cold Laser:
HCPCS Level II Code S8948 will be recognized by the System and approved for the treatment of neck conditions.

CPT Code 97039 or 97026 will be recognized by the System and automatically denied as experimental and investigational. Appeals to this denial can be addressed to the Director of Chiropractic Services with supporting documentation.

Maintenance or Custodial Level Care:
Maintenance or Custodial Level care is specifically excluded from all plan benefit designs. Submitting Maintenance or Custodial care for payment will be viewed as a breach of your contract and will result in termination from our network.

Elective Chiropractic Care:
HCPCS Level II Code S8990 can be used to indicate Elective Chiropractic Spinal Manipulation. It will be automatically denied by the system as not meeting the Plan definition of Medically Necessary.

ICD-9-CM code V13.59 can be used to indicate Elective Chiropractic management. It will be automatically denied by the system as not meeting the Plan definition of Medically Necessary.

In these cases, our system recognizes this as you knowingly submitting a non-covered service. Correctly submitting with this code will not be viewed as a breach of contract but rather as you properly executing a Non-Covered Service Agreement. You may do this to assist one of your patients (our member or participant) in accessing their Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA). This allows you to meet both your contractual demands and your patient’s (our member’s or participant’s) expectations.
4A. Continuous Quality Improvement Efforts

Arise Health Plan is engaged in continuous quality improvement and expects all of our Participating Providers to embrace the process of providing the best health care that research supports. Greater detail of this process is located in the Provider Directory section of our website at: www.WeCareForWisconsin.com

4B-1a. Quality Reporting Compensation

Low Back Pain (LBP) is the most common condition treated by chiropractors. Properly reporting quality codes qualifies participating chiropractors for additional compensation. This program uses the 2012 PQRS Medicare Reporting Codes on submitted claims for our qualified members and participants. This program is available only for contracted, participating chiropractors and only for the following codes. Exact rates of compensation for specific codes are defined in your Provider contract. All Arise Health Plan compensated code sets and their interpretations are substantially abbreviated versions of the codes Medicare recognizes for the conditions/procedures. This is not intended to be comprehensive. A comprehensive list of PQRS reporting codes can be found at: http://www.cms.gov/PQRS/15_MeasuresCodes.asp

PQRS Back Pain Measures Group Reporting

Arise Health Plan is adopting only this substantially abbreviated version of reporting of PQRS for the Back Pain Measures Group for qualification in the additional compensation.

For claim submission reporting (the only way we are accepting this measure – Arise Health Plan will not recognize Registry or Qualified EHR submission for this program), there are 2 HCPCS codes that need to be billed on the same date of service every time this is being reported:

G8493: I intend to report the Back Pain Measures Group

AND

G8502: All quality actions for the applicable measures in the Back Pain Measures Group have been performed for this patient

They are tied to only these patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

One of the following diagnosis codes indicating back pain:

Only this abbreviated version qualifies for compensation.
4B-1b. Quality Reporting Compensation-Care and Health Promotion.

The profession of chiropractic has defined the “minimum” clinical health promotion expectations as “All DCs Should Screen All Patients (i.e., Those Presenting for Symptomatic Treatment or for Wellness Care) for the Following Risk Factors.

1. Obesity/overweight, by means of obtaining a body mass index on all patients.
2. Physical inactivity or sedentary behaviors, by means of asking patients about their usual levels of activity.
3. Tobacco use, both current and former.
4. Hypertension, detected by in-office mercury or aneroid sphygmomanometry using an upper arm cuff, as recommended by the USPSTF.”


Arise Health Plan supports this effort. Half of these expectations are directly or indirectly included in the Back Pain Measures Group and are compensated with those reporting codes. Reporting for the rest of these expectations is compensated for as defined below.

This program uses the 2012 PQRS Medicare Reporting Codes on submitted claims for our qualified members and participants. This program is available only for contracted, participating chiropractors and only for the following codes. Exact rates of compensation for specific codes are defined in your Provider contract. All Arise Health Plan compensated code sets and their interpretations are substantially abbreviated versions of the codes Medicare recognizes for the conditions/procedures. This is not intended to be comprehensive. A comprehensive list of PQRS reporting codes can be found at: http://www.cms.gov/PQRS/15_MeasuresCodes.asp

PQRS Tobacco use: Screening and Cessation Intervention Reporting

Arise Health Plan is adopting only this substantially abbreviated version of reporting of PQRS for the Tobacco use: Screening and Cessation Intervention reporting for qualification in the additional compensation.

For claim submission reporting (the only way we are accepting this measure – Arise Health Plan will not recognize Registry or Qualified EHR submission for this program), there is one CPT code that needs to be billed on the same date of service every time this is being reported:

4004F: Tobacco use: Screening and Cessation Intervention

It is tied to only these patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Only this abbreviated version qualifies for compensation.

PQRS- Hypertension (HTN): Plan of Care

Arise Health Plan is adopting only this substantially abbreviated version of reporting of PQRS for Hypertension (HTN): Plan of Care for qualification in the additional compensation.
For claim submission reporting (the only way we are accepting this measure – Arise Health Plan will not recognize Registry submission for this program), there are 2 Codes that need to be billed on the same date of service every time this is being reported:

- **G8752** Systolic BP < 140mmHg
- **G8753** Systolic BP ≥ 140mmHg

  **AND**

- **G8754** Diastolic BP < 90mmHg
- **G8755** Diastolic BP ≥ 90mmHg

They are tied to only these patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

They are tied to one of the following diagnosis codes for Hypertension:

401.0, 401.1, 401.9,

Only this abbreviated version qualifies for compensation.

**PQRS- High Blood Pressure Control in Diabetes Mellitus**

Arise Health Plan is adopting only this substantially abbreviated version of reporting of PQRS-for High Blood Pressure Control in Diabetes Mellitus for qualification in the additional compensation.

For claim submission reporting (the only way we are accepting this measure – Arise Health Plan will not recognize Registry or Qualified EHR submission for this program), there are 2 CPT Codes that need to be billed on the same date of service every time this is being reported for the most recent blood pressure performed:

- **G8919** Systolic BP < 140mmHg
- **G8920** Systolic BP ≥ 140mmHg

  **AND**

- **G8921** Diastolic BP < 90mmHg
- **G8922** Diastolic BP ≥ 90mmHg

They are tied to only these patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

They are tied to one of the following diagnosis codes indicating Diabetes Mellitus:

250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

Only this abbreviated version qualifies for compensation.
4C. Statistical Mix of Practice Styles

Your performance will be measured statistically against your peers by Arise Health Plan. If your performance substantially deviates from the care your peers are providing (coding, under or over utilizing, etc.), you will be subject to coaching from the Director of Chiropractic Services. Continued substantial deviation from the panel mean will result in your termination from the panel.

4D. Forms and Worksheet

Arise Health Plan makes every possible attempt to minimize additional paperwork for you to participate with Us.

4D-i. Non-Covered Services Agreement

A Non-Covered Services Agreement is available by special request of the Director of Chiropractic Services.

4D-ii. Pre-Service Authorization Form

Arise Health Plan makes every possible attempt to minimize additional paperwork for you to participate with Us.

The Pre-Service Authorization Form is a requirement for some Participating Providers.

4D-iii. NIA Pre-Service Authorization Worksheet for Advanced Imaging

Arise Health Plan makes every possible attempt to minimize additional paperwork for you to participate with Us.

The NIA Pre-Service Authorization Worksheet is an attempt to help you organize your thoughts prior to initiating the Pre-Service Authorization process. It is not a mandatory form. Information, including the guidelines for, diagnostic imaging can be accessed at the NIA web site: www.RadMD.com

RE: Pre-Service Authorization now required for MRI’s you order for Arise Health Plan Member or Participant

For Arise Health Plan members and participants to receive CT and MRI at the highest level of benefits, you must Pre-Service Authorize these services. This Pre-Service Authorization requirement affects all outpatient MRI’s or CT’s for all provider types: MD, DO and DC. This process is supervised by NIA (National Imaging Associates, Inc.) and NOT at Arise Health Plan. You must request the Pre-Service Authorization from NIA.

The NIA guidelines are available at their web site (www.RadMD.com).

You can complete the on-line profile and submit your Pre-Authorization.

Support for this process is available from NIH.
5A. Excerpts from Plan Language

**Medically Necessary** means services, treatment, supplies, or facilities, which 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.

**Custodial or Maintenance Care** is care received after the Covered Person has achieved a maximum level of improvement or plateau in progress, as determined by Us. The care includes Activities of Daily Living. Please refer to the Definition of Activities of Daily Living. The determination of Custodial or Maintenance Care is made by Us after reviewing a Covered Person’s case history or treatment plan submitted by a Practitioner.

**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 practices, 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.

The evidence must consist of well-designed and well-constructed 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.

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.

**EXCLUSIONS AND LIMITATIONS**

This Policy will not pay for expenses incurred for the following services, procedures, or supplies.

**GENERAL EXCLUSIONS**

B. Services, supplies, facilities, or equipment that We determine are not Medically Necessary.

C. Services, supplies, facilities, or equipment that We determine are Experimental or Investigational, except for routine care required by law for clinical trials.

H. Custodial or Maintenance Care.