

Please share our news.

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



We care for Wisconsin.

UNDERWRITTEN BY WPS HEALTH PLAN, INC.



HMO/POS Commercial Products

New HEDIS Measures

As part of our commitment to quality, Arise Health Plan gathers medical data on our members for HEDIS® (Healthcare Effectiveness Data Information Set). The annual chart review process starts in March and concludes in May. If one of your patients is selected as part of the random sample, you or your office staff will receive a call or letter from the quality department requesting to review the applicable medical record. We appreciate your cooperation in gathering this data. Our goal is to exceed the 90th percentile nationally based on Quality Compass® statistics in each of the measures.

One change in the HEDIS® specifications this year involves the Diabetes Measure. The Blood Pressure control changed from <130/80 to <140/80.

A new measure is Plan All-Cause Readmission which tracks reasons for hospital readmissions and adjusts rates of readmission based on past comorbidities, primary

discharge conditions, presence of major surgery, age and gender. The new measure helps health plans, hospitals and others compare readmission rates in order to take actions to provide optimal care to reduce unnecessary readmission.

If you have any questions about the HEDIS® measures please feel free to contact the quality department at 490-6956.

this issue

- Practitioner Rights Pertaining to Credentialing P.2
- Health Insurance Timeliness Standards P.2
- Independent Review Process In Wisconsin P.3
- Arise Supports Text4baby P.3
- New Website Coming Soon P.3
- Claims Resolution Matrix 2011 P.4

Practitioner Rights Pertaining to Credentialing

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

- You have the right, upon request, to be informed of the status of your application at any time, and to review a summary of information obtained by the Credentialing Department for the purpose of evaluating your application, excluding confidential peer references and evaluations or information that is peer review protected.
- You will be promptly notified of information that varies significantly from the information you have provided and be given the opportunity to submit

updated/additional documentation or corrections. The correction of erroneous information must be done, in writing, within ten (10) days of being notified of the varying information by the Credentialing Department. The Credentialing Department is not obligated to reveal the source of information if disclosure is prohibited by law.

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

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

Health Insurance Timeliness Standards

The National Committee on Quality Assurance, or NCQA, of which Arise Health Plan is accredited, mandates we must abide by Timeliness Standards in making care determinations for members of our health plan. An insurance concept that is misunderstood by many is the turnaround time of decision-making.

Arise Health Plan will usually make a pre-service authorization decision, and have a letter with that decision in the mail to our members within 2 or 3 business days. If we have the necessary clinical information either on a pre-service authorization request itself, or faxed/mailed along with the request, it takes very little time to reach a decision and get a letter in the mail to our members and care providers.

If we cannot make a decision based upon the information on the pre-service authorization request, we may need to ask for medical records. Quite often, waiting for medical records dramatically delays our decision-making ability. This is usually where Timeliness Standards come into play. With a non-urgent pre-authorization request for services, Arise Health Plan has 15 calendar days from receipt of the

request to make a decision and notify our member and the involved care provider of our decision. If the needed care is deemed urgent, Arise Health Plan must make a decision and notify the involved parties within 24 hours of receipt of the request.

If we cannot make a decision to cover services by these deadlines, we must notify our members and care providers that such a decision cannot be made and an extension is necessary. We must also state by which date we think we will be able to reach a decision. If review of medical records is required to make a decision, Arise Health Plan must allow the provider's office up to 45 calendar days to provide the needed medical records. Once the requested medical records are received, Arise Health Plan has 15 days to make a pre-service authorization decision and 30 days for a decision on services that have already been provided.

Arise Health Plan must abide by these standards as part of maintaining our accreditation with NCQA. We consistently strive to best these standards, which is one of the reasons NCQA accredited Arise Health Plan with the level of "Excellent"!

Independent Review Process in Wisconsin

As with any product or service, members may have questions or complaints about their health insurance plan. Members should first attempt to resolve a complaint by contacting the health plan's Members Services department locally at (920) 490-6900 or 888-711-1444 toll-free and press option 1. Members may also file a grievance with the insurer. All insurance companies offering health benefit plans in Wisconsin are required to have an internal grievance process to resolve complaints from the member or the member's authorized representative.

If members are not satisfied with the outcome of their grievance, a Wisconsin law provides the opportunity for all persons covered by health benefit plans an additional way to resolve disputes involving medical decisions.

Members may request an independent review if coverage was denied because:

- Services were deemed not medically necessary;
- Services were considered experimental or investigational;
- Services were rendered by an out-of-network practitioner whose clinical expertise was felt to be medically necessary and the expertise is not available from an in-network practitioner;
- Services were for a pre-existing condition exclusion; or
- The policy or certificate was rescinded.

The independent review process provides members with an opportunity to have medical professionals who have no connection to their health plan review their dispute. The decision of the IRO is binding on the health plan and the member for medical necessity and experimental or investigational determinations. The IRO decision regarding pre-existing conditions and rescission is only binding on the health plan.

When a coverage request is initially denied, a list of certified Independent Review Organizations (IROs) is provided along with information on how to request a review. Independent review is available only after the grievance procedure has been completed. Members may be entitled to an expedited independent review when certain situations apply.

A request for an independent review must be made within four months of the date of the adverse determination or experimental treatment determination, or from the date of receipt of notice of the grievance panel decision, whichever is later.

If you have any questions or need additional information, please contact Arise Health plan locally at (920) 490-6900 or 888-711-1444 toll-free, the Wisconsin Office of the Commissioner of Insurance (OCI) at 800-236-8517, or visit OCI's website at www.oci.wi.gov.

Arise Health Plan Supports Text4baby

Text4baby is a free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB), text4baby provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life.

Women who sign up for the service by texting BABY to 511411 (or BEBE in Spanish) will receive free SMS text messages each week, timed to their due date or baby's date of birth. For more information about this program, please contact Paula Soletski at 920-490-6956 or www.text4baby.org.

New Website Coming Soon

Arise Health Plan will soon launch a new and improved website. Please visit www.wecareforwisconsin.com for information on Arise Health Plan's drug formulary, authorization requirements, provider manual, and other

helpful tools and resources. You may also obtain paper copies of this information by calling our Member Services Department at 920-490-6900 or 1-888-711-1444. Stay tuned for more updates.

NIA Claim Matrix 2011 – Arise Health Plan

NIA (National Imaging Associates, Inc) operates as a review service for medical imaging claims. This matrix is designed to assist in the resolution of claims adjudication and claims questions related to those services managed by NIA. The matrix below contains all those CPT-4 codes NIA manages on behalf of its clients. The codes listed are set up utilizing what would be seen on a professional HCFA 1500 claim and not UB-92 claim. The inclusion of a code(s) also doesn't imply that the service would be approved, only that if we received a request for that service, it would be managed by NIA.

Each procedure is tracked and managed by NIA using the "CPT/HCPCS Code Managed by NIA". The "Allowable Billed Groupings" is meant to outline that if a given procedure is authorized, that any of the listed procedures codes could be submitted on a claim representing that service. This assumes, of course that appropriate

rebundling rules are applied and that the service is performed within the date of service validity period. Codes representing contrast agents, radiopharmaceuticals and supplies are not listed on this matrix.

Codes that are submitted by facilities using CMS Outpatient PPS logic (C codes) and utilizing UB 92 claim logic are also not incorporated into this table.

If a family of CPT codes is not listed in this matrix, an exact match is required between the authorized CPT code and the billed CPT code. If the exact match does not occur, the charge should be adjudicated accordingly.

**Please note: Services rendered in an Emergency Room, Observation Room, surgery center or hospital inpatient setting are not managed by NIA.*

Authorized CPT Code	Description	Allowable Billed Groupings
70336	MRI Temporomandibular Joint	70336
70450	CT Head/Brain	70450, 70460, 70470
70480	CT Orbit	70480, 70481, 70482
70486	CT Maxillofacial/Sinus	70486, 70487, 70488, 76380
70490	CT Soft Tissue Neck	70490, 70491, 70492
70496	CT Angiography, Head	70496
70498	CT Angiography, Neck	70498
70540	MRI Orbit, Face, and/or Neck	70540, 70542, 70543
70551	MRI Internal Auditory Canal	70551, 70552, 70553, 70540, 70542, 70543
70544	MRA Head	70544, 70545, 70546
70547	MRA Neck	70547, 70548, 70549
70551	MRI Brain	70551, 70552, 70553
70554	Functional MRI Brain	70554, 70555
71250	CT Chest	71250, 71260, 71270
71275	CT Angiography, Chest (non coronary)	71275
71550	MRI Chest	71550, 71551, 71552
71555	MRA Chest (excluding myocardium)	71555
72125	CT Cervical Spine	72125, 72126, 72127
72128	CT Thoracic Spine	72128, 72129, 72130
72131	CT Lumbar Spine	72131, 72132, 72133
72141	MRI Cervical Spine	72141, 72142, 72156
72146	MRI Thoracic Spine	72146, 72147, 72157
72148	MRI Lumbar Spine	72148, 72149, 72158
72159	MRA Spinal Canal	72159
72191	CT Angiography, Pelvis	72191
72192	CT Pelvis	72192, 72193, 72194
72196	MRI Pelvis	72195, 72196, 72197
72198	MRA Pelvis	72198
73200	CT Upper Extremity	73200, 73201, 73202
73206	CT Angiography, Upper Extremity	73206
73220	MRI Upper Extremity, other than Joint	73218, 73219, 73220
73221	MRI Upper Extremity Joint	73221, 73222, 73223

73225	MRA Upper Extremity	73225
73700	CT Lower Extremity	73700, 73701, 73702
73706	CT Angiography, Lower Extremity	73706
73720	MRI Lower Extremity, other than Joint	73718, 73719, 73720, 73721, 73722, 73723
73721	MRI Lower Extremity Joint	73721, 73722, 73723, 73718, 73719, 73720
73721	MRI Hip	72195, 72196, 72197, 73721, 73722, 73723
73725	MRA Lower Extremity	73725
74150	CT Abdomen	74150, 74160, 74170
74175	CT Angiography, Abdomen	74175
74176	CT Abdomen and Pelvis Combination	74176, 74177, 74178
74181	MRI Abdomen	74181, 74182, 74183, S8037
74185	MRA Abdomen	74185
74261 3	Diagnostic CT Colonoscopy (Virtual Colonoscopy, CT Colonography)	74261, 74262
74263 3	Screening CT Colonoscopy (Virtual Colonoscopy, CT Colonography)	74263
75557	MRI Heart	75557, 75559, 75561, 75563, +75565
75572	CT Heart	75572
75573	CT Heart congenital studies, non-coronary arteries	75573
75574	CTA coronary arteries (CCTA)	75574
75635	CT Angiography, Abdominal Arteries	75635
76380	Follow Up, Limited or Localized CT	76380, 70486, 70487, 70488
76390	MR Spectroscopy	76390
77058	MRI Breast	77058, 77059
77084	MRI Bone Marrow	77084
78451	Myocardial Perfusion Imaging – Nuclear Cardiology	78451, 78452, 78453, 78454, 78466, 78468, 78469, 78481, 78483, 78494, 78499 Also included in this auth is the corresponding 9- range (93015-93018) and the radiopharmaceutical charges (A9500-A9604).
78459	PET Scan, Heart	78459, 78491, 78492 Also allow billing for the corresponding Cardiovascular Stress Test 9-range (93015 – 93018)
78472	Muga Scan	78472, 78473, +78496 Also included in this auth is the corresponding 9- range (93015-93018) and the radiopharmaceutical charges (A9500-A9604).
78608	PET Scan, Brain	78608, 78609
78813 1, 2	PET Scan	78811, 78812, 78813, 78814, 78815, 78816
78816 1, 2	PET Scan with concurrently acquired CT for attenuation correction and anatomic, localization.	78811, 78812, 78813, 78814, 78815, 78816
G0235	PET imaging, any site, not otherwise specified	G0235
S8037	MR Cholangiopancreatography	S8037, 74181, 74182, 74183
0042T	Cerebral Perfusion Analysis CT	0042T

- 1 NIA will not be making a medical necessity determination as to which of these codes are appropriate. Instead, we will make a determination as to whether the PET scan itself is indicated and then expect the imaging facility to bill in a fashion that accurately describes what was performed.
- 2 The 78814 series describes a PET scan where CT technology is used to better “focus” the PET scanning. When an ordering physician requests a PET scan, they won’t know whether or not an older machine will be used without the CT component. NIA’s tumor imaging clinical guidelines does not make a distinction between which technique is used. If a PET scan is clinically indicated, use of either series of codes is acceptable. Accordingly, we are expanding the list of “Allowable Billable Groupings” to take this into account. These codes are NOT to be used for a study typically called

- 3 PET fusion. A PET fusion study is where a PET Scan and a diagnostic CT scan are performed on the same machine simultaneously. Under this situation one is instructed by CPT to bill using both the PET CPT code and the CT scan code describing the body region and procedure performed. The CT code should be appended with a modifier 59 to ensure proper payment. When receiving such requests, NIA will review the medical necessity for both the PET scan and the CT scan and issue UM determinations on both codes.
- 3 CT Colonography also known as Virtual Colonoscopy – NIA’s guidelines currently cover diagnostic CT Colonography (74261 and 74262) under predefined situations. We currently find the screening CT Colonography (74263) as not being medically necessary.