PROVIDER MANUAL

AUGUST 2024

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Revision Log

Updates are regularly made to the information in this manual. The grid below outlines changes that have been made to the manual from its immediate predecessor version. Refer to the Historical Revision Log as a reference to past revisions.

Description of Change	Link	Page
Added: Language Line Instructions	Health Equity and Prevea360	9
Added: Transition of Commercial products		All
Updated: Availity Essentials Provider Portal Information for payer ID 41822		All
Added: Instamed information to include payer ID 39113		All
Updated: Information regarding new payer ID 41822		All
Added: Information regarding new payer ID 41822		All
Removed: Prevea360 Advantage references		All
Added: Customer Service IVR information for payer ID 41822	Directory	6
Updated: Provider information components to ensure current and accurate provider information is in the Provider Directory.	Provider Changes for Directory Accuracy	12
Added: Sample member ID card images	Examples of Member Identification Cards	19
Updated: Health Plan Provider News as a monthly newsletter.	Health Plan Communications for Providers	22
Updated: Credentialing section.	Credentialing Processes	24
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Updated: Case management information throughout to reflect current program offerings and contact information	Case Management	63
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WELCOME!

Welcome to the Prevea360 Health Plan provider network. Thank you for participating in our network of physicians, clinics, hospitals, and other healthcare professionals. We are delighted to work with you. As an in-network provider, you are part of our comprehensive network that encourage patients to seek their health care locally and will be listed in our online Provider Directory easily accessible to members from the Find a Doctor link located at the top of Prevea360 Health Plan web pages. You also have access to our Provider Network Consultants who are personnel dedicated to supporting our in-network providers.

ABOUT THIS MANUAL

Not an in-network provider, but would like to become one?

The information in this Provider Manual is applicable to in-network providers contracted with Prevea360 Health Plan to provide services to Prevea360 Health Plan members. Request to join the network by submitting our online Provider Network Application, located at the bottom of the Prevea360 Health Plan Providers Resources page at Prevea360.com/Providers. Our Provider Network Services team contacts interested providers upon receipt of the request.

This Prevea360 Health Plan Provider Manual is a resource for policies and practices for claim submission and procedural expectations to support in-network providers serving patients enrolled in Prevea360 Health Plan benefit plans. It also includes important phone numbers, website URLs, and references to provider resources and how to access them. This manual is intended to be extension of the provider contract. As such, providers should also refer to their contract agreement, the member's benefit certificate, medical policy, and applicable state and federal laws for specific coverage information.

Prevea360 Health Plan began transitioning to a new claims processing platform in January 2024. As part of this multi-year migration, payer ID 41822 was created to gradually transition our business to this new platform by member plan type. The information in this manual is meant to apply broadly across all plans and payer IDs, but will indicate when different processes are required based on the use of payer ID 41822 or 39113, the payer ID used most commonly in our legacy business platforms. Beginning with our Individual and Family Business (IFB/ACA plans) on January 1, 2024, those that have transitioned to our new claims platform and processes will utilize payer ID 41822. The Commercial lines of business will begin to transition upon renewal starting May 1, 2024. Members that have transitioned to the new payer ID of 41822 will receive new member ID cards that will indicate payer ID 41822. We will continue to announce updates on which products are transition on our Provider Communications page of the website. Plans utilizing legacy payer ID 39113 and Dean Administrative Services Only (ASO) payer ID 75261 will remain the same, using processes and resources that were effective prior to January 1, 2024. New plan types set to make the transition and use payer ID 41822 will be broadly announced and documented.

Prevea360 Health Plan offers a separate, supplemental provider manual for the Dean Administrative Services Only (ASO) product. This provider manual is cited in the "Products" section of this manual and can be consulted for additional product specific details.

Updates to this manual are made on a regular basis. New changes that have been made to the manual from its immediate predecessor version are documented in the Revision Log. Refer to the Historical Revision Log as a reference to recent past revisions.

Providers are strongly encouraged to refer to the online version of this manual to ensure they have the most current information.

TIPS ON NAVIGATING THE MANUAL

Clarification of Terms

In this manual, “you,” “your,” “practitioner,” or “provider” refers to any health care provider subject to the information in this manual, including physicians, health care professionals, facilities, and ancillary providers; except when indicated otherwise.

“We” and “our” refers to the health plan.

“Members” and “patients” refer to individuals enrolled in Prevea360 Health Plan benefit plans.

Finding Information

The Table of Contents links to the applicable section within the manual. To search using a specific keyword:

1. Select CTRL+F.
2. Type in the key word.
3. Click Enter.

We are here to help!

If you have questions about information in this manual or can’t find the information that you are seeking, please refer to the directory on the next page to contact the appropriate department or to access the applicable resource. When in doubt, please don’t hesitate to contact our Customer Care Center at the number on the member ID Card.

DIRECTORY

Refer to the directory below to contact the appropriate department or access the applicable resource for assistance.

CUSTOMER SERVICE	
Prevea360 Health Plan for Payer ID 39113	(877) 230-7555
Prevea360 Health Plan for Payer ID 41822	(800) 458-5512
Customer Care Center Monday – Thursday 7:30 am to 5:00 pm Friday 8:00 am to 4:30 pm	
Prevea Care After Hours	(920) 496-4700 | toll-free (888) 277-3832
Language Assistance Line for In-Network Providers Available 24 hours a day, 7 days a week	(844) 526-1386
HEALTH SERVICES	
Utilization Management	(800) 356-7344 ext. 4455
Point of Service Prior Authorizations	(800) 356-7344 ext. 4455
Care and Disease Management	(866) 905-7430
Care Management Fax Number	(952) 992-3589
CLAIMS	
Claims Manager	(877) 232-7566
Information Systems for Electronic Claims Transmission	dhpedi@prevea360.com
ELECTRONIC DATA INTERCHANGE	
Information about Electronic Data Interchange (EDI) transactions	• HIPAA transactions web page • edi@prevea360.com
Electronic Payor ID	39113
	41822
DRUG PRIOR AUTHORIZATIONS	
Drug Prior Authorization and Reconsiderations Fax	(920) 735-5350
Navitus Health Solutions	(866) 333-2757
WEBSITES AND MAILING ADDRESSES	
Prevea360 Health Plan Website	Prevea360.com
Navitus Pharmacy Benefits Website	Navitus.com
Address – Madison Hub	Prevea360 Health Plan PO Box 56099 Madison, WI 53705
PROVIDER NETWORK CONSULTANTS	
Find your assigned Provider Network Consultant for your specialty. If your specialty does not have a designated Provider Network Consultant, contact the Provider Network Consultant for your county.	Go to Prevea360.com/Providers and scroll to the bottom of the web page. Occasionally there are changes to our Provider Network team. Refer to our website for the most current information.

Customer Care Center IVR

For plans under our new payer ID 41822, we are implementing an automated phone system technology, Interactive Voice Response (IVR). The IVR system offers 24/7 self-service for member eligibility, benefits, or claim status information through pre-recorded prompts, and menu options. You'll always have the option to exit the IVR and speak with a live call agent during business hours. To utilize the IVR system have the following information ready:

- Organization 9-digit tax ID number
- Member's Group and ID numbers for 2024

ABOUT PREVEA360 HEALTH PLAN

Prevea360 offers a comprehensive network of hospitals, providers and specialty physicians in Eastern and Western Wisconsin. Dean Health Plan, the underwriter for all Prevea360 Health Plan policies, is headquartered in Madison, WI. Dean Health Plan and Prevea Health are partners for the Prevea360 Health Plan with Dean Health Plan serving as the provider contracting and claims processing administrator for Commercial and Administrative Services Only (ASO) lines of business in the Prevea360 network service areas. In 2021, Dean Health Plan entered into a partnership with Medica, an independent, non-profit health plan headquartered in Minnetonka, Minnesota. This affiliation brings Prevea360 Health Plan into the Medica family. The Medica family includes Medica, with headquarters in Minnetonka, MN, as well as Dean Health Plan and Medica Central Health Plan, previously WellFirst Health with coverage in southern Illinois, Missouri and select areas of Oklahoma.

The Prevea360 network includes the following counties:

- Barron
- Brown
- Buffalo
- Calumet
- Chippewa
- Crawford*
- Door
- Dunn
- Eau Claire
- Jackson*
- Kewaunee
- La Crosse*
- Manitowoc
- Marinette
- Menominee
- Monroe*
- Oconto
- Outagamie
- Pepin
- Pierce*
- Shawano
- Sheboygan
- St. Croix*
- Trempealeau*
- Vernon*

*Counties added to the network to serve enrollees in the State of Wisconsin Employee Trust Fund (ETF) product. In addition, members who are enrolled in an existing Prevea360 Health Plan Commercial plan (fully insured, including ACA) or Dean Administrative Services Only (ASO) plans have access to services from in-network Prevea360 Health Plan providers in these counties.

HEALTH EQUITY AND PREVEA360 HEALTH PLAN

Health equity means that every person has the opportunity to be as healthy as possible. As a health plan, we recognize that addressing health inequities and promoting cultural awareness are key for delivering a diverse and inclusive experience for members. In support of this, Prevea360 Health Plan espouses the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to advance health equity and help eliminate health care disparities.

Understanding and implementing the National CLAS Standards ensures higher quality care to all patients. Prevea360 Health Plan expects all network providers to support health equity standards and deliver honest, unbiased, and respectful care regardless of a patient's race, ethnicity, language, sexual orientation, or gender identity.

Prevea360 Health Plan encourages providers to collect information regarding a patient's race, ethnicity, preferred language, sexual orientation, and gender identity to ensure health care services are meeting the multi-cultural needs of that individual. Requests for this information should be conducted respectfully in a sensitive and unbiased manner that also upholds a patient's privacy.

For more information, trainings, and other resources regarding health equity, please visit the Prevea360 Health Plan's Cultural Awareness & Health Equity web page.

Language Line

To address diverse language needs and enable important communications between providers and patients, Dean Health Plan offers a free telephonic Language Line for language assistance/interpreter services. The Language Line is available to in-network providers who do not have access to language assistance services and need to interact with Health Plan members who have limited English language proficiency.

How to access an interpreter/use the language line:

- Call the Language Line at 844-526-1386, available 24 hours a day, 7 days a week.
    - You will be prompted to indicate the language needed:
        - Press 1 for Spanish. This will directly connect you with a Spanish-speaking interpreter.
        - Press 6 for all other languages. This will prompt you to indicate which language you need interpretation services for.
        - After confirming the language needed, you will be connected to an interpreter.
    - The interpreter will share their name and ID number at the beginning of the call. They will ask you for:
        - Your name and/or the name of the provider performing service.
        - The clinic or facility name where the service is being provided
        - The member's name or their member ID number.
    - You'll also brief the interpreter on any special communications or needs.
        - The interpreter will also ask if this is an in-person call (the member is with you) or a third-party call is needed (to connect you and the interpreter to the member who is at another

location). If a third-party call is required, the interpreter will ask for the member's telephone number and initiate a three-way call.

Working with an interpreter

- Note the interpreter's name and ID number provided at the beginning of the call for future reference.
- Once engaged with the member, speak directly to that individual, not the interpreter.
- Pause at the end of a complete thought to allow time for the interpreter to convey the information to the member. To ensure accuracy, your interpreter may ask you for clarification or repetition.

Using phone interpreting equipment

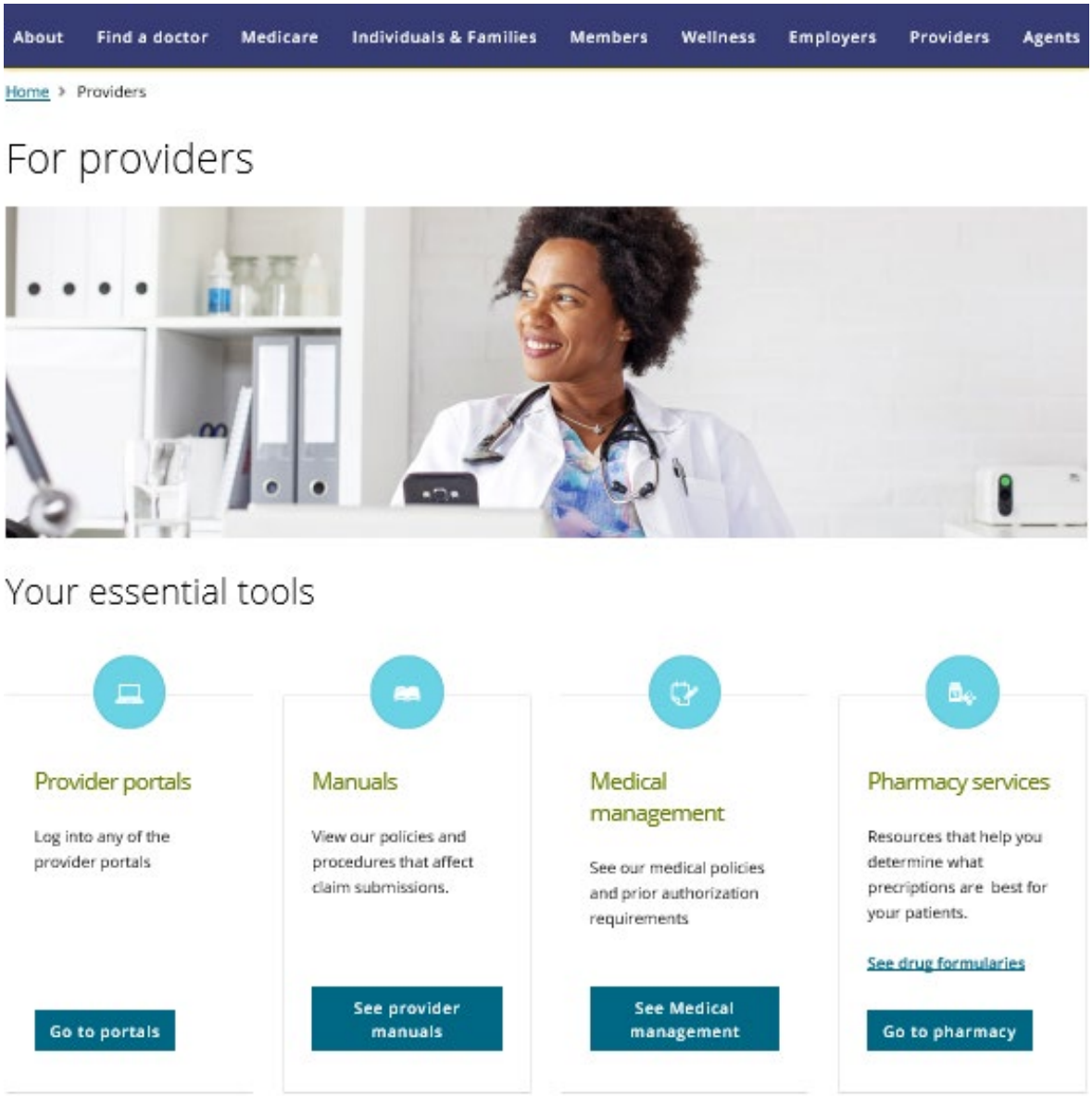
If you have phone interpreting equipment for in-person calls, use one handset to call the Language Line. Once connected, give the second handset to the member.

Customer service

If you wish to provide feedback on your Language Line experience, email Provider Network Services. Along with your feedback, include your name, company/organization, date/time of your call, interpreter's name and ID number, and the member's ID number.

VISIT OUR WEBSITE

Preave360 Health Plan offers provider information and resources from the For Providers home page. This page is directly at Prevea360.com/Providers or by hovering over **For Providers** located at the top, right of the screen and clicking **Overview**.



PROVIDER NETWORK SERVICES

Prevea360 Health Plan's Provider Network Services' main purpose is to support in-network providers. This includes maintaining provider files, administering the provider contracting process, updating provider manuals, and issuing provider communications.

PROVIDER NETWORK CONSULTANTS

The Provider Network Services Department includes our Provider Network Consultants (PNCs), who are responsible for educating all existing and new in-network Prevea360 Health Plan providers. Provider education includes:

- Updating our providers on new policies and procedures via email, the *Provider News* newsletter, provider mailings, or workshops.
- Orientations for new practitioners and facilities.
- Ongoing education for network providers such as processes for day-to-day interaction with the health plan.

Go to Prevea360.com/Providers and scroll to the bottom of the web page to find the Provider Network Consultant for your specialty. If your specialty does not have a designated Provider Network Consultant, contact the Provider Network Consultant for your county.

NETWORK SETUP AND PROVIDER STATUS

Prevea360 Health Plan is a closely managed health maintenance organization (HMO) comprised of contracted in-network providers to provide health care services to our members. In order to provide quality coverage and cost savings to our members, there are two distinct statuses for providers based on how they are contracted with Prevea360 Health Plan:

- **Plan** — referred to as an in-network provider in this manual. This is a provider with a "Plan" status who is contracted as an in-network Prevea360 Health Plan provider who can provide health care services to Prevea360 Health Plan members and is listed in our provider directory.
- **Non-Plan with Agreement** — referred to as an out-of-network provider in this manual. This is a provider with a "Non-Plan with Agreement" status who is contracted to provide services to Prevea360 Health Plan members; however, is not considered to be a "Plan" or in-network provider due to their specific contract language. These providers require a prior authorization to be submitted to the health plan by an in-network provider on their behalf for approval before providing services to Prevea360 Health Plan members. (Unless the member has a PPO or POS plan – then an authorization is only needed if the service requires authorization).

Providers contracted with Prevea360 Health Plan may only be allowed to provide care to Prevea360 Health Plan members for specific products, practitioners, services, and/or locations. It's important for providers to be familiar with their provider agreement and always check member eligibility prior to providing services in order to prevent claims payment issues.

A non-plan/non-contracted provider is an out-of-network provider that does not have a signed contract with Prevea360 Health Plan. The Health Plan has no liability or responsibility for the quality of care provided by an out-of-network provider.

Out-of-network providers can request to join the Prevea360 Health Plan network by completing and submitting our online Provider Network Application.

PROVIDER CHANGES FOR DIRECTORY ACCURACY

We are committed to ensuring that our provider directories are accurate and current for members who rely on this information to find in-network providers for their care. Additionally, the Centers for Medicare & Medicaid Services (CMS) and other regulatory and accreditation entities require us to have and maintain current information in our provider directories requires that we keep provider information up to date.

To help accomplish this, providers must notify their Provider Network Consultant of any updates to their information on-file with us as soon as they are aware of them. Notify your assigned Provider Network Consultant if there are changes to the following data elements:

Practitioner Data Elements	Location Data Elements
Practitioner Name	Location Name
Degree/Title	Address
Specialty	Phone Number
Ability to Accept New Patients	Handicap Accessible
Board Certification	Website URL
Gender	Accepted Plan Types at Location
Language(s) Spoken by Practitioner	Language(s) Spoken at Location
Telehealth Available ○ Telehealth Optional / Telehealth Only ○ Modalities (chat, phone & video) ○ 3rd Party Caregiver	Handicap Accessible
Language(s) Spoken by Practitioner	Services
Participating Hospital Affiliation(s)	
Practice Locations	

On a quarterly basis, outreach is provided by our vendor BetterDoctor requesting providers to validate their information on-file with us is current and accurate. Providers should not wait for these reminders to update their information with the Health Plan.

Providers must also notify the Health Plan of terminations for individual practitioners, clinics, facilities and any other locations under an organization. Communicate the terminations in writing to your assigned Provider Network Consultant with as much advance notices as possible.

As we prepare our provider directories to accommodate additional information for our in-network providers and additional requirements in the future, please review your directory information regularly at Prevea360.com/Find-A-Doctor to verify it reflects current and accurate information for you and your organization.

Providers are encouraged to review and update their National Plan and Provider Enumeration System (NPPES) information when they have changes. NPPES provides information such as name, specialty, address, and telephone number for virtually every provider in the country in a machine-readable format. NPPES data serves as an important resource to improve provider directory reliability and accuracy.

REQUESTING TO JOIN THE NETWORK

Providers can request to join Prevea360 Health Plan's network of contracted providers by completing and submitting our online Provider Network Application, located at the bottom of the Pevea360 Health Plan "For providers" page at Prevea360.com/Providers.

Our Provider Network Services team contacts interested providers upon receipt of the request. Requests are reviewed and may take extended time to make a determination. The determination will be communicated to you by a Provider Network Consultant.

Providers are not considered in-network providers until they have satisfied all credentialing requirements, completed the credentialing process (whether at the organization or practitioner level), have a signed agreement, and are configured in Prevea360 Health Plan's system. Once these are all completed, the provider will be notified, generally via email, of the date they are approved to begin providing services to Prevea360 Health Plan members and submit claims for these services. For information on credentialing and recredentialling, refer to the Credentialing Process section in this document.

REQUESTING A NEW PRACTITIONER, LOCATION, OR SERVICE

In-network providers must formally request new practitioners, additional offices or practice locations, and services/specialties through their assigned Provider Network Consultant in writing. Requests should be communicated and submitted **in advance** to your assigned Provider Network Consultant, whose information can be found at Prevea360.com/Providers.

The request process is as follows:

1. Provider requests a new practitioner, location, or specialty in writing to their Provider Network Consultant. Providers should also specify if the new practitioner is replacing a practitioner in the organization. If so, include the practitioner's name, specialty, degree, and term date in the request.
2. The Provider Network Consultant may require the provider to provide additional information or documentation, which will then be submitted to the health plan for review.
3. The health plan reviews and makes a determination on the request:
    - If denied:
        1. The Provider Network Consultant will notify the provider of the denial. Denials remain on file for 12 months and therefore providers must wait for that time period before submitting a new request.
        2. .
    - If approved:
        1. The Provider Network Consultant will notify of the approval and instruct on whether the new practitioner must undergo credentialing.
            - If credentialing is not required, the new practitioner's credentialing effective date is the same as the notification date.
            - If credentialing is required, the new practitioner will receive a credentialing application to complete and submit.
                - The new practitioner cannot provide services to Prevea360 Health Plan members until their credentialing is approved.
                - No retroactive effective dates are granted.

2. The new practitioner will be notified once credentialing is successfully passed, and they can begin providing services to Prevea360 Health Plan members and claims can be submitted for the new practitioner, location, or service.

Mid-Level Practitioners and Locum Tenens Physicians

The Prevea360 Health Plan network is composed of many practitioner types, including locum tenens physicians and physician extenders/mid-level practitioners such as nurse practitioners (NP/APNP) and physician assistants (PA/PA-C).

- Mid-level practitioners and locum tenens physicians are required to complete the credentialing process.
- Prevea360 requires our plan providers to send **advance** notification of the need for a locum tenens physician. Please contact your Provider Network Consultant to request a locum tenens physician and their expected time coverage.
- Mid-level practitioners must have a supervising physician. When requesting a mid-level practitioner, please include the supervising physician's name, degree, specialty and practice location.

Replacement Practitioner

If requesting a practitioner who will be replacing an existing practitioner who is terming from your organization, please ensure the terming practitioner's name, specialty, degree and term date is included in the request.

ORGANIZATION AND PRACTITIONER UPDATES

It is important to report organization and practitioner changes to Prevea360 Health Plan. Failure to do so may impact claims processing and payments. Report any of the following changes or updates to your assigned PNC for your organization with as much **advance notice** as possible to avoid claims payment issues:

Practitioner-Related

- Name change
- Adding or discontinuing specialty
- Moving locations – including when moving to another in-plan organization
- Hospital affiliations
- Leave of absence, vacation, or extended leave
- Medicare certification/decertification (claims will not be retroactively paid)
- Terminating from your organization (see next section)

Organization-Related

- Name change
- Accreditation or decertification
- Billing information (TIN or NPI)
- Taxonomy
- Physical change to billing or practice location addresses on file with Prevea360 Health Plan
- Selling or transferring ownership
- Clinic closure
- Facility handicap accessibility
- Website URL

PRACTITIONER TERMINATIONS

Providers must notify their patients in writing in advance when terming from an organization. Notifying Prevea360 of practitioner terminations is also required, as Prevea360 Health Plan adheres to the state statute for Continuity of Care. Please communicate any practitioner terminations in writing to your Provider Network Consultant with as much **advance notice** as possible (minimum of 30 days prior to the termination), and include the following info:

- Practitioner name and degree
- Practice location(s)
- Termination date
- Reason for termination (i.e., moving to a new practice, retirement, etc.)
- Where the practitioner will be providing services (if still actively practicing)
- A copy of your member notification letter communicating the practitioner's termination

FACILITY TERMINATIONS OR CLOSURES

Providers must notify their patients in writing in advance if a site is closing permanently. Notifying Prevea360 of clinic or practice site terminations/closures is necessary, as Prevea360 Health Plan adheres to the state statute for Continuity of Care. Please communicate any in-network clinic terminations or closures in writing to your Provider Network Consultant with as much **advance notice** as possible (minimum of 60 days prior to the termination), and include the following info:

- Location name
- Address
- Termination date
- If practitioners at that site are moving to another location
- A copy of your member notification letter communicating the termination/closure

OTHER SITUATIONS

Please communicate the following situations to your Provider Network Consultant in writing:

- Leave of Absence/Vacation: when a practitioner will be out of the office, vacationing, or on extended leave, and another facility or location will be covering their practice.
  Prevea360 Health Plan requires **written** notification to include:
  - Name
  - Location
  - Duration of the covering practitioner or facility

  The covering practitioner must be an in-network **provider** and have completed the credentialing process**.**
- Panel Status: when a practitioner finds it necessary to discontinue accepting new patients or limit their practice. This update must be received to the Provider Network Consultant in writing.

PROVIDER SERVICE OBJECTIONS

Providers in the Prevea360 Health Plan network who refuse to provide a service to members based on moral or religious objections must notify their Provider Network Consultant in writing of the objection and its basis in a timely manner. Prevea360 Health Plan will notify the member so that the member can seek another like network provider that is available to provide the service in question.

TERMINATION OF PATIENT/PRACTITIONER RELATIONSHIP POLICY AND PROCEDURE

In-network providers are required by Prevea360 Health Plan to send copies of member termination of care notification letters to their assigned Provider Network Consultant.

Practitioners may terminate a member's care only with good cause. The following are examples of good cause, in which a member:

- Physically injured or threatened a practitioner or other member of the clinic staff.
- Repeatedly and materially refused to pay coinsurance, copayments, or deductibles associated with Prevea360 claims after all reasonable collection efforts have been exhausted.

- Displayed verbally abusive behavior or harassment towards a practitioner or other member of the clinic staff.
- Repeatedly refused to cooperate with the practitioner, was non-compliant with medical care, or there was a breakdown in the practitioner-patient relationship.
- Failed to attend or late cancel three or more scheduled appointments after having received a written warning.
- Communicated to the practitioner that they would like to select a different practitioner.

The following should be included in the termination of care letter, per Prevea360 guidelines:

1. Member's full name, including middle name (not just initial)
2. Member's date of birth (optional)
3. Member's address, which can be in address line
4. Clinic/facility name
5. Practitioner name
6. Notice in the body of the letter stating that the member may see the practitioner for 30 days from the date the member received the termination notice if the member presents for urgent or emergent care
7. Reason for the termination
    - If reason is due to the member missing or late-canceling appointments, include when their initial warning letter was sent to them.
8. If reason was due to non-payment, include proof of attempts to collect payment
9. Prevea360 Health Plan's Customer Care Center phone number listed on the member ID card.
10. Copy of a patient authorization form, as the member may want to transfer care to a different clinic/facility

PRODUCTS

Prevea360 Health Plan offers a variety of products for its employer groups; each designated to serve specific needs. Beginning with our Individual and Family Business (IFB/ACA plans) on January 1, 2024, those that have transitioned to our new claims platform and processes will utilize payer ID 41822. Commercial lines of business will begin to transition upon renewal starting May 1, 2024. Members that have transitioned to the new payer ID of 41822 will receive new member ID cards that will indicate payer ID 41822. We will continue to announce updates on which products are transition on our Provider Communications page of the website. Below is an overview of the plans that are available.

- **Prevea360 Network Plan** is based on a managed care model in which members select an in-network primary care provider from our extension network who oversees all aspects of their care. This product also offers many wellness programs to promote healthy habits and good health to members and their families. Members can see their primary care provider without authorization. Out-of-network services require an authorization from an in-network Prevea360 Health Plan provider, with the exception of urgent or emergency care services. Under this managed care model, women members can choose to see a women's health specialist (OBG/GYN) without an authorization.

- **Prevea360 Point of Service (POS) Plans** not only offer members Network coverage, but also the freedom to see the providers of their choice, regardless of if they are Prevea360 in-network providers. Members are not required to choose a primary care provider and authorization is not needed to see a specialist. However, when members receive care from Prevea360 Health Plan in-network providers, they will have lower out-of-pocket costs.

- **Prevea360 Preferred Provider Organization (PPO) Plans** are for employer groups who have employees living outside of the Prevea360 Health Plan service area and therefore may not have nearby access to the Prevea360 Health Plan provider network. To provide Prevea360 PPO members access to local, regional, and national provider network, Prevea360 contracts with wrap network First Health. First Health has a robust provider network of physicians and facilities outside of the Prevea360 service area. Prevea360 Health Plan PPO member ID cards have both the Prevea360 Health Plan and First Health logos. See a sample Member ID card for this product.

- **Administrative Services Only (ASO)** is a self-funded insurance arrangement whereby an employer provides benefits to employees with its own funds. This is different from fully insured plans where the employer contracts an insurance company to cover the employees and dependents. In self-funded health care, the employer assumes the direct risk for payment of the claims for benefits. The terms of eligibility and covered benefits are set forth in a plan document which includes provisions similar to those found in a typical group health insurance policy. Refer to the Administrative Services (ASO) web page for more information.
  Note: In some case, self-funded ASOs employer groups are not required to follow all State or Federal health care mandates. Therefore, ASO self-funded employer groups policies may be different from those of health plan. Please contact the Customer Care Center at 877-234-4516 or online at deancare.com/contact-us/contact to obtain coverage information for a specific employer group.

- **Prevea360 Western WI Health Plan for State of WI Employees** is a benefit plan only available to State of Wisconsin employees and their dependents in Crawford, Jackson, La Crosse, Monroe, Pierce, St. Croix, Trempealeau, and Vernon counties. The provider network for this benefit plan is the State of WI ETF – Prevea360 West and Mayo Clinic Health System network. The Mayo Clinic Health System locations in the network are accessible to ETF enrollees only through Dean Health Plan's partnership with Medica. Non-ETF enrollees assigned to the Prevea360 West provider network do **not** have access to Mayo Clinic Health System facilities and providers. Prevea360 Health Plan's policies, prior authorization requirements, and claim submission processes in this manual apply to this product, unless otherwise noted. See a sample Member ID card for this product.
- **Prevea Partnered Health (PPH)** is a health insurance benefit design that Prevea360 offers to participating employer groups and their dependents. See a sample Member ID card for this product. PPH allows certain services, including

urgent care and physical and occupational therapy to be rendered at certain Prevea Health locations at a reduced copay. Providers need to be aware of the following when submitting PPH claims for these services:

- Claims must have the appropriate National Provider Identifier (NPI) indicated. The appropriate NPI for these claims is not the primary NPI used for other claims.
  Note: Some entities have received special direction for their NPIs for those claims and should follow that direction, in those cases.
- Claims will not be reprocessed. Claims submitted with the incorrect NPI will not be reprocessed. Providers must submit a corrected claim with the appropriate NPI. This must be done within the timely filing timeframe.
- There is no appeal process for claims billed with the incorrect NPI.

- **Prevea360 Health Plan Individual Family and Business (IFB)/ACA on and off exchange Plans** are for individuals who do not have health insurance coverage through an employer. Prevea360 Health Plan offers multiple plans with a variety of deductible and benefit levels to meet an individual's needs. As of 1/1/2024 these plans will use payer ID 41822.

AUTOMATIC ASSIGNMENT OF PRIMARY CARE PROVIDER

If a member does not designate a primary care provider site and/or practitioner, Prevea360 Health Plan will automatically assign one based upon the member's residence. In these situations, Prevea360 Health Plan will send a letter to the member informing them of the assigned primary care provider site or practitioner. . Members can contact the Customer Care Center at the phone number on the member ID card with questions.

Members enrolled in a POS or PPO benefit plan have access to providers in the Prevea360 Health Plan provider network, but also have the option to go outside of the provider network for primary or specialty care. A prior authorization maybe required for certain services. Members incur higher out-of-pocket costs if they choose to pursue care under the POS benefit, but have more flexibility for their care.

EXAMPLES OF MEMBER IDENTIFICATION CARDS

The Prevea360 Health Plan member ID cards are differentiated by the Product Type in the upper, right-hand corner on the front of the card. Members who have a different deductible/coinsurance maximum amount from their out-of-pocket maximum amount, also have their deductible/coinsurance maximum amount listed on their member ID card, as shown in the member ID card image for Commercial and ACA Individual further below.

The member ID card images, below and on the following page, are provided as examples only as member ID cards may differ from the images shown.

PPO IDENTIFICATION CARD – Payer ID 39113

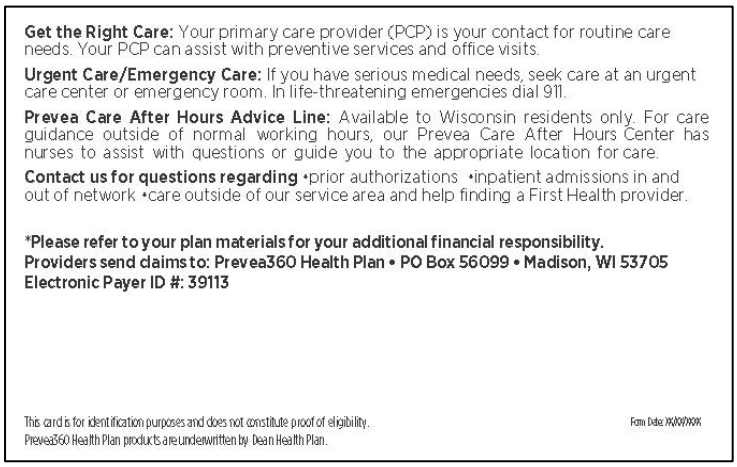

PREVEA360 health plan
First Health Network

Network: Prevea360
Group Number: XXXXXXXXXXXX
Product Type: PPO
prevea360.com

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

In/Out Network Deductible*: Individual $XXXXX/$XXXXX Family $XXXXX/$XXXXX
In/Out Network Ded/Coinsurance Max*: Individual $XXXXX/$XXXXX Family $XXXXX/$XXXXX
In/Out Network Out of Pocket Max*: Individual $XXXXX/$XXXXX Family $XXXXX/$XXXXX
PCN: 6104 • BIN: 610602

Customer Care: 877-230-7555 (TTY 711) • Prevea Care After Hours: 888-277-3832


Get the Right Care: Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.

Urgent Care/Emergency Care: If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.

Prevea Care After Hours Advice Line: Available to Wisconsin residents only. For care guidance outside of normal working hours, our Prevea Care After Hours Center has nurses to assist with questions or guide you to the appropriate location for care.

Contact us for questions regarding •prior authorizations •inpatient admissions in and out of network •care outside of our service area and help finding a First Health provider.

***Please refer to your plan materials for your additional financial responsibility.**
Providers send claims to: Prevea360 Health Plan • PO Box 56099 • Madison, WI 53705
Electronic Payer ID #: 39113

This card is for identification purposes and does not constitute proof of eligibility.
Prevea360 Health Plan products are underwritten by Dean Health Plan.

Form Date: XX/XX/XXXX

BACK

COMMERCIAL HMO IDENTIFICATION CARD– Payer ID 39113


PREVEA360 health plan

Network: Prevea360
Group Number: XXXXXXXXXXXX
Product Type: HMO
prevea360.com

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

SAMPLE

Deductible*: Individual $XXXXX Family $XXXXX
Ded/Coinsurance Max*: Individual $XXXXX Family $XXXXX
Out of Pocket Max*: Individual $XXXXX Family $XXXXX
PCN: 6104 • BIN: 610602

Customer Care: 877-230-7555 (TTY 711) • Prevea Care After Hours: 888-277-3832

FRONT


Get the Right Care: Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.

Urgent Care/Emergency Care: If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.

Prevea Care After Hours Advice Line: Available to Wisconsin residents only. For care guidance outside of normal working hours, our Prevea Care After Hours Center has nurses to assist with questions or guide you to the appropriate location for care.

Contact us for questions regarding •prior authorizations •inpatient admissions in and out of network •care outside of our service area and help finding a First Health provider.

SAMPLE

***Please refer to your plan materials for your additional financial responsibility.**
Providers send claims to: Prevea360 Health Plan • PO Box 56099 • Madison, WI 53705
Electronic Payer ID #: 39113

First Health Network

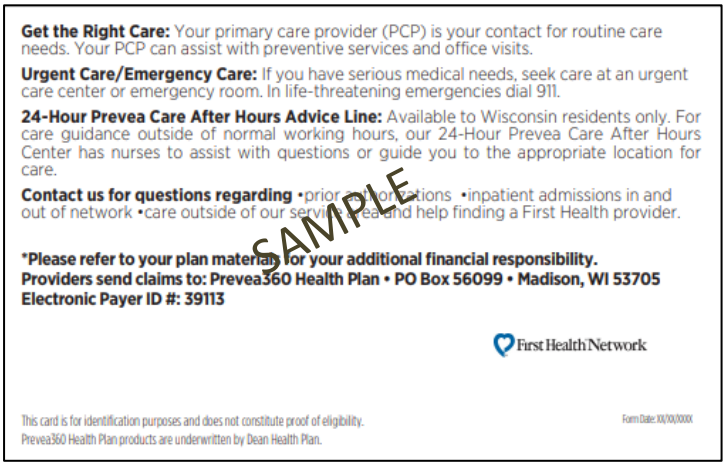
This card is for identification purposes and does not constitute proof of eligibility.
Prevea360 Health Plan products are underwritten by Dean Health Plan.

Form Date: XX/XX/XXXX

BACK

PREVEA360 WESTERN WI HEALTH PLAN FOR STATE OF WI EMPLOYEES

FRONT



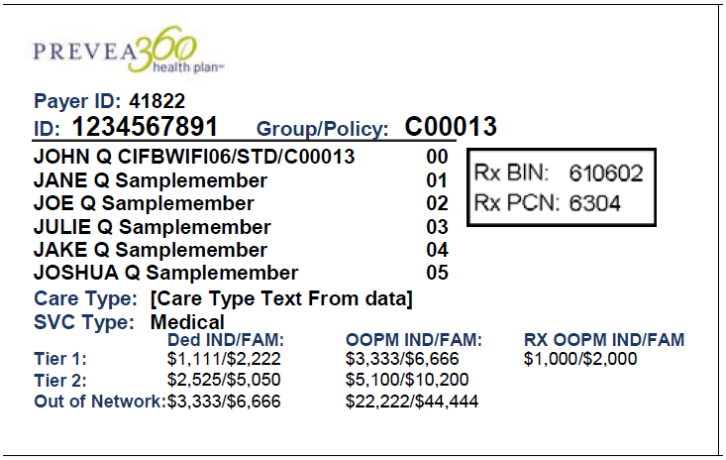
BACK

PARTNERED HEALTH IDENTIFICATION CARD

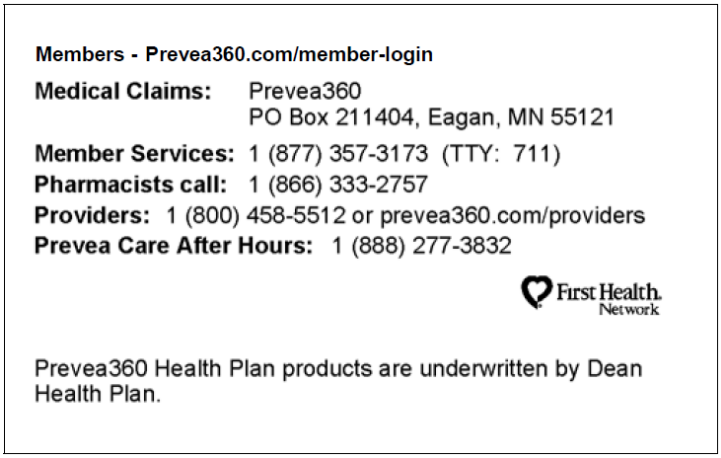
FRONT

BACK

INDIVIDUAL & FAMILY BUSINESS (IFB)/ACA PLANS – PAYER ID 41822



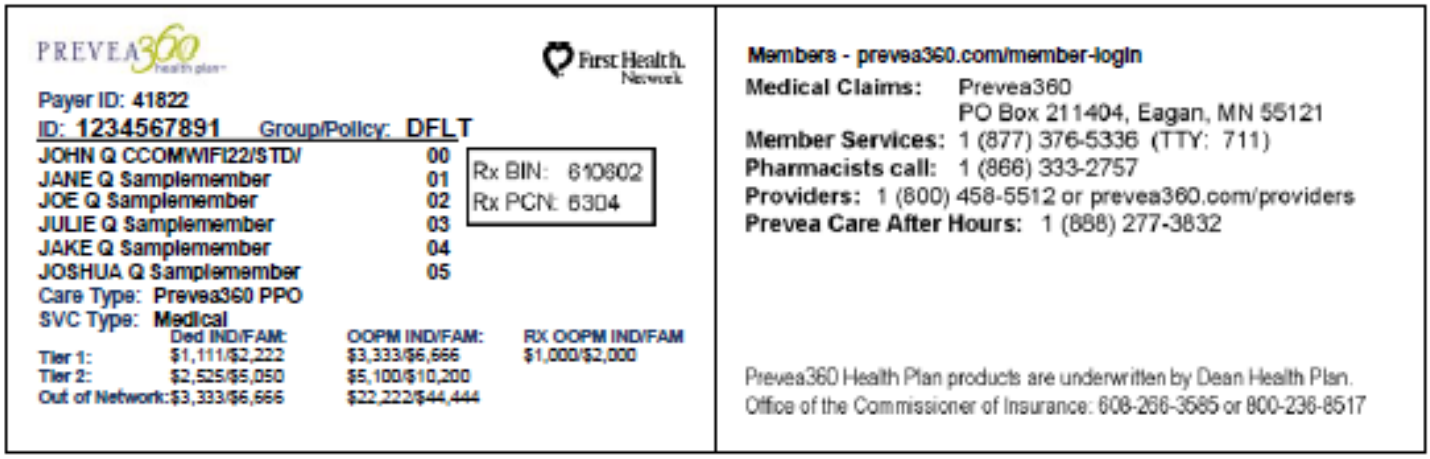
FRONT



BACK

Note: The listed copay amount, as shown on the card example directly above, varies based on the employee's plan option.

COMMERCIAL HMO IDENTIFICATION CARD– PAYER ID 41822



CHECKING MEMBER ELIGIBILITY

Providers should verify member eligibility for each date of service and cannot charge a member for failing to do so and providing services. Because Prevea360 Health Plan products vary and members can move between eligibility groups, it is important that providers determine member eligibility using real-time eligibility sources only — the 270/271 Eligibility and Benefit Inquiry and Response transaction **or** the Eligibility application in the Prevea360 Health Plan Provider Portal accessible from the Account Login page. For payer ID 41822, use the Availity Essentials Portal or when necessary, contact the Customer Care Center. The information in these transactions also includes real-time details about a member's cost share, deductible, copay, and coinsurance amounts.

For Payer ID 39113, member health plan benefit information, including certificate of coverage, member policy or certificate can be viewed at MemberBenefits.Prevea360.com by entering the full member ID or group number. Use Google Chrome to access.

Providers may call our Customer Care Center at the phone number on the member ID card with any questions about a member's eligibility and coverage.

HEALTH PLAN COMMUNICATIONS FOR PROVIDERS

Prevea360 Health Plan issues a variety of communications to providers about changes to health plan procedures, benefits, and other areas of interest involving health plan products and services:

- **Prevea360 Health Plan *Provider News*** — a monthly health plan newsletter specifically for Prevea360 Health Plan in-network providers. The Prevea360 Health Plan *Provider News* informs providers of changes to health plan procedures, benefits, and other areas of interest involving health plan products and services.
- **As-needed communications** — to communicate changes outside of the quarterly newsletter schedule due to the planned implementation date or for larger initiatives that require more detail.
- **Policy update provider notifications** – emailed monthly to communicate select medical benefit drug policy and medical policy updates as well as Health Plan initiatives, when applicable. Monthly provider notifications are also published to the Provider Communications page.
- **Provider Communications page** — links to a variety of our past and current provider notifications that were originally communicated via postal mailings or emails to serve as an on-demand communications repository. Examples of the notifications available from this page are monthly policy update provider notifications and the annual plan and benefit changes information. Published communications contain information that was accurate when the notification was originally released and may not reflect current information. The Provider Communications page is the hub for updates and communications regarding updated interim process for self-service as we transition to our new business platforms.
- **Provider Onboarding Guide** — useful reference for all in-network providers, accessible from the Provider Communications page. The brief document highlights specific areas of business or functionality in "grab and go" sections. Also, includes a Quick Reference for easy access to a variety of resources. Please note that information in the Onboarding, while useful for all in-network providers for Prevea360 Health Plan, features processes only applicable for member plans that utilize payer ID 39113.
- **Portal Messages** — accessible from the Prevea360 Health Plan Provider Portal (as relevant for payer ID 39113) to temporarily communicate general messaging regarding topics such as system outages or directing providers to resources or more detailed communications for full information. These messages are archived in the provider portal and available for review after acknowledgement.

In most cases, we communicate to providers through email. To enable this more efficient method of communication, providers are encouraged to select the Opt In option to receive direct and expedited provider email communications from Prevea360 Health Plan. Opt In is available in the Prevea360 Health Plan Provider Portal during the Provider Portal registration process and also can be selected after registration through Account Settings. The opt-in captures contacts information for providers providing services for all plan types, including those utilizing payer ID 41822.

MEMBER INFORMATION FOR PROVIDERS

Prevea360 Health Plan offers a wide range of programs and services to improve the overall health of our communities and support providers caring for individuals enrolled in Prevea360 Health Plan benefit plans. While the available member services and programs are intended for patients who are enrolled in Prevea360 Health Plan benefit plans (and some are even available regardless of insurance), providers are encouraged to be familiar with member resources and promote them to their patients, when appropriate.

A wealth of details regarding member programs and services are featured on the Prevea360 Health Plan website ranging from behavioral health resources, nutritional programs, health and wellness webinars and events, preventive care, and more. To assist providers in finding this online information, the Prevea360 Health Plan Member Resources Reference

Guide for Providers is published on the Prevea360 Health Plan Provider Communications page. The reference guide is organized alphabetically by the name of the Program/Service with a brief description. Direct links are provided in the reference guide for use if viewing the document online, as well as the navigational path to access the online information if viewing the printed document.

CREDENTIALING PROCESS

PRACTITIONER CREDENTIALING AND RECREDENTIALING PROCESS

The Health Plan adheres to a credentialing/recredentialing process for evaluating and selecting practitioners who practice within the Health Plan delivery system. The Health Plan is National Committee on Quality Assurance (NCQA) accredited, and therefore requires specific documentation is reviewed within established timelines during the credentialing/recredentialing process. Practitioner credentialing applications are reviewed and approved by the Health Plan's Credentialing Subcommittee or its delegate prior to being authorized to provide services to Health Plan members. Recredentialing applications are required to be completed and approved by the Health Plan Credentialing Subcommittee at least every 36 months to continue to provide services to Health Plan members. The attached link includes the full Credentialing Plan shared by the Medica family of brands: Partner.Medica.com/-/Media/Documents/Provider/Programs-and-Resources/Medica-Credentialing-Plan.pdf?la=en

If an organization has entered into a Delegation of Credentialing Agreement with Dean Health Plan, credentialing/recredentialing for practitioners within that organization are delegated to their organizational group. In these cases, the terms of the credentialing/recredentialing process are outlined in the delegation agreement and may differ slightly from the process overview in this manual.

PROVIDER PORTAL

USING PREVEA360 HEALTH PLAN PROVIDER PORTALS

Prevea360 Health Plan uses two provider portals to ensure providers have access to 24/7 self-service. For payer ID 39113, our health plan-specific provider portal registration and functionality is described in detail below. Beginning January 1, 2024, multi-payer solution Availity Essentials will serve as the main location to exchange clinical and administrative data for members in plans under payer ID 41822, indicating they have transitioned to our new claims platform. Please note that providers will need to continue to do business out of both portals until all of our membership has transitioned off of the legacy systems. While full functionality is being activated within Availity Essentials, interim processes may be utilized and will be detailed on our Provider Communications page.

OVERVIEW AND RESOURCES FOR AVAILITY ESSENTIALS

Availity Essentials enables provider teams to perform transactions for multiple payers from a single account. Essentials will be available for all member transactions as plan types transition to payer ID 41822, our Individual and Family Business (IFB/ACA plans) transition effective January 1, 2024. Our Commercial lines of business will begin to transition upon renewal starting May 1, 2024. Availity Essentials is a widely utilized provider portal between health plan payers and providers. If your organization uses Availity Essentials for another payer, our new payer ID 41822 for Prevea360 Health Plan will be added as an option to your dashboard. There's nothing you need to do. If your organization doesn't use Availity Essentials, visit the Availity Essentials web page.

Logging-in, Training and Troubleshooting with Availity

Availity's Prevea360 Health Plan provider set-up and resource page can be found ***HERE*** or from availity.com/medica-health-plans. This page also allows you to sign up for live webinars, or play a Prevea360 Health Plan-specific recorded training to get to know a particular application or function better. Please note that not all Availity functionality will be available during our member transition, but updates on additional available functionality will be located on our Provider Communications page.

OVERVIEW OF PORTAL/FUNCTIONALITY

The Prevea360 Health Plan Provider Portal is a 24/7 online resource for our in-network providers free of charge to assist with managing key patient data, simplify everyday tasks, promote efficiency in business and streamline electronic transactions. It has functionality to check HIPAA-compliant real-time transactions along with web-based self-service applications. While the health plan transitions to a new claims platform, this portal only applies to information for members in plan types utilizing payer ID 39113. Work pertaining to members in plan types utilizing payer ID 41822 is available in Availity Essentials.

We strongly encourage providers to establish a Provider Portal Account!

If you are not interacting with the health plan through the Provider Portal for payer ID 39113, we strongly encourage you to establish a Portal account. Once a Portal account is created, users can access information and perform tasks specific to their assigned Portal role(s). Individuals need to register in order to create a secure Provider Portal account. Refer to the Prevea360 Health Plan Provider Portal Registration User Guide for the simple step-by-step process on how to create Individual and Organizational Provider Portal accounts. The Portal Registration User Guide and other account

setup resources including a short video are available from the Prevea360 Health Plan Account login page at ProviderAuth.Prevea360.com.

Note: Dean Health Plan ASO members are **not** on the Prevea360 Health Plan Provider Portal. Refer to the Administrative Services Only Product Manual for portal information the Administrative Services (ASO) web page for more information.

ACCESS THE PROVIDER PORTAL

There are two ways to access the Provider Portal:

1. From Prevea360.com:
    a. Hover over the "Providers" link and select **Overview** to go to the "For providers" page
    b. Click the **Go to Portals** link located under "Provider portals"
    c. Click **Provider portal login**
2. For Payer ID 39113 -directly at ProviderAuth.Prevea360.com
3. For Payer ID 41822 – directly at Apps.Availity.com/Web/Onboarding/Availity-fr-ui/#/login

PROVIDER PORTAL APPLICATIONS

This section details options available in the Prevea360 Health Plan Provider Portal applicable to business using payer ID 39113. As we transition business to payer ID 41822, check the Provider Communications page to verify availability of the applications listed here in the Availity Essentials and any applicable interim solutions.

Eligibility & Benefits (270/271 EDI) Transactions

This application provides human readable real time Electronic Data Interchange (EDI) 270/271 Eligibility & Benefit Inquiry and Response transactions, including detail regarding eligibility, benefit plan coverage, co-payments, and deductibles for a member. It also provides the member's primary health plan, if applicable.

Authorization

Submit electronic prior authorization requests through the Provider Portal's Authorization application, for most services. There are some exceptions to the type of authorization requests that can be submitted through the Provider Portal. Prevea360 Health Plan contracts with the following entities for authorization review and approval of certain services, applicable to both payer ID 39113 and 41822:

- Navitus/Navi-Gate — for pharmacy benefit drug authorization requests
- NIA Magellan — for authorization of physical and occupational therapy, high-end radiology services, and musculoskeletal services.

Links to the Navitus/Navi-Gate portal and NIA Magellan portal are conveniently available on our Account Login page.

Refer to the Submitting Prior Authorization Requests for more information as well as tips for prior authorization submissions.

Authorization View

See your authorizations that have been started and saved, and authorizations that have been completed and submitted.

Claim Status (EDI 276/277) Transactions

This application provides human readable real time EDI 276/277 Health Care Claim Status Request and Response transactions, which allows providers to check the status of a claim to see if it is pending, processed, or in a finalized status. *Note*: Claims cannot be submitted via the Prevea360 Health Plan Provider Portal.

- Claim Payments
- This application will allow a user to view electronic remittance files or search by a variety of criteria including a Keyword search.

- For Payer ID 39113 - This application is only available for historic Change Healthcare prior to claims processed on or before February 9, 2024. For claims processed after February 9, 2024, claims payment can be viewed in the Instamed Portal.
- For Payer ID 41822 claims payment can only be viewed in the Instamed Portal.

Claim Appeals
This application allows users to appeal processed claims with a finalized status (paid-denied).

Provider Admin
Allows Provider Portal Site Administrators to make updates to Individual user or Organization account information.

Provider Resources page
Repository of convenient links to provider resources such as medical policies, user guides, provider manuals, and partner portals.

For more information on applications, refer to the Prevea360 Health Plan Provider Portal User Guide for payer ID 39113 available on the secure Provider Resources page once you have established your Portal account. For payer ID 41822 resources are available with Availity Essentials.

Opt In/Opt Out for Electronic Communications in the Provider Portal
The Opt In for electronic communications option is available in the Prevea360 Health Plan Provider Portal in "Account Settings." By selecting Opt In, providers will receive direct and expedited provider email communications from Prevea360 Health Plan. No communication preferences are available specific to Prevea360 Health Plan in the Availity Essentials Portal, so please ensure that your Prevea360 Health Plan portal account reflects this preference to ensure that your email is collected for this purpose.

Communications include notifications about changed or new policies or upcoming changes that may affect daily operations, for example. Opt In will not replace all paper communications. Email addresses that are provided to the health plan through Opt In will not be shared with outside organizations or used for purposes other than the electronic distribution of health plan communications.

Prevea360 Health Plan will email communications to the email address that was provided during registration. Check your email "junk" or "spam' folders periodically to ensure that communications are not being filtered as spam. Prevea360 Health Plan will not send a high volume of emails; however, you may want to consult your IT department if you have not received an email from Prevea360 Health Plan after three months of your Portal registration.
While Opt In is available through the Portal, opting out after selecting Opt In can be done through the "Unsubscribe" link at the bottom of email communications that you will receive from Pevea360 Health Plan. Once you unsubscribe, your email address is automatically inactivated from the system and further electronic communications cannot be sent to that address.

EDI TRANSACTIONS

Electronic Data Interchange (EDI)

Prevea360 Health Plan offers HIPAA-compliant electronic transactions to providers to meet consistent documentation, handling and privacy standards as well as for efficiency. Go to the HIPAA Transactions page accessible from Provider Resources page at Prevea360.com to view the Prevea360 Health Plan supported transactions, companion guides, EDI setup forms, and additional information. This page is organized by payer ID. Please be sure to establish new payer ID 41822, access through the Availity gateway, with your clearinghouse to ensure that transactions can be performed, our Individual and Family Business (IFB/ACA plans) transition effective January 1, 2024. Our commercial lines of business will begin to transition upon renewal starting May 1, 2024.

Eligibility and Benefit Inquiry and Response (270/271)

The most timely and accurate way to confirm a member's benefits and coverage amounts is to submit an eligibility request transaction. Prevea360 Health Plan supports this transaction in either real-time or batch. To engage in EDI transmission, please complete an EDI setup form or if you use a clearinghouse or billing service, have them reach out to us to arrange transmission.

Health Care Claim Submission (837)

Electronic claim submission allows for standardized transmission of claims data, resulting in fewer rejections and more streamlined claims adjudication. Prevea360 Health Plan accepts the 837 Health Care Claim: Professional (837P) and Institutional (837I) transactions. To submit claims electronically, please complete an EDI setup form or if you utilize a clearinghouse or billing service have them reach out to us.

Claim Acknowledgment (277CA)

Electronic claim acknowledgment files are a response to the electronic claim submission (837) files we receive. Each claim is identified individually as to whether it was accepted for processing or was rejected. Reasons for rejections are also supplied in the response.

Health Care Claim Status Request and Response (276/277)

Electronic claim status requests allow inquiry and response to quickly know the status of a claim that had been accepted for adjudication. Prevea360 Health Plan supports this transaction in either real-time or batch. The provider should wait a minimum of 30 days after claim submission to send a claim status response to allow for the known payment processing time. To engage in EDI transmission, please complete an EDI setup form or if you use a clearinghouse or billing service have them reach out to us to arrange transmission.

Health Care Claim Payment/Remittance Advice (835) and Electronic Funds Transfer (EFT) for payer ID 39113

For claims processed prior to February 9, 2024, Prevea360 Health Plan contracts with Change Healthcare as our clearinghouse for the exchange of both electronic remittance advices (ERA) and electronic funds transfers (EFT), as well as paper explanation of payments (EOP) information and checks. To access by phone Change Healthcare ePayment Services at 866-506-2830 or online at ChangeHealthcare.com/support/Customer-Resources/Enrollment-Services.

For claims processed after February 10, 2024, Prevea360 Health Plan contracts with Instamed to manage payment services (i.e, remittance advice, Explanation of Payments (EOP), electronic funds transfer (EFT) and paper checks). Providers can visit Instamed.com/eraeft to register.

For Payer ID 41822

Prevea360 Health Plan contracts with Instamed to manage payment services (i.e, remittance advice, Explanation of Payments (EOP), electronic funds transfer (EFT) and paper checks. Providers can visit Instamed.com/eraeft to register.

EDI Help Desk - If you have questions related to EDI setup, data content, or other EDI issues please contact our EDI team directly at edi@prevea360.com.

CLAIMS, TIMELY FILING, AND ADJUSTMENTS

Claims Submission

To allow for more efficient processing of your claims, we ask for your cooperation with the following:

- Prevea360 Health Plan requires providers to use the correct and complete member number. Families share the first nine digits of their subscriber number, for payer ID 39113. For payer ID 41822 families share the first 10 digits of their subscriber number. The remaining two digits signify the individual member (i.e., spouse, dependents, etc.). Using the correct member numbers on the claims submitted to Prevea360 Health Plan will help us ensure correct claim payment.
    - For payer ID 39113 the complete eleven digit member number is required for claims submission.
    - For payer ID 41822 **ONLY** the first 10 digits are required for claims submission. If the claim is submitted with the full 12 digits the claim will be rejected.
- Prevea360 Health Plan requires contracted providers to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. For more information, refer to the Timely Filing Guidelines section.
- Prevea360 Health Plan requires that all services billed be appropriately documented in the patient's medical records. If the services billed are not documented in the patient's medical record, they will not be considered reimbursable by Prevea360 Health Plan.
- All claims for services regarding work-related injuries or illness should be submitted to the worker's compensation carrier. If the worker's compensation carrier denies claims, you may submit the claim along with the denial for consideration by Prevea360 Health Plan. **All prior authorization guidelines apply in this situation.** You must submit the claim(s) in a timely manner along with the denial as outlined in the timely filing guidelines.
- Submit subrogation claims (where the third party may have caused the injury or illness due to an auto accident, a slip or fall, and/or a defective product) to Prevea360 Health Plan for processing. We will pursue recovery of those expenses from the at-fault party and/or their liability insurer. **All prior authorization guidelines apply in this situation.** You must submit the claim(s) in a timely manner as outlined in the timely filing guidelines.
- While Prevea360 Health Plan will accept paper or electronically submitted claims, it's recommended to submit electronically to expedite processing and reduce claim rejections. All claims submitted, regardless of submission method, must comply with the applicable national billing rules as well as the published Companion Guides. Only the latest published versions of the claim forms will be accepted for processing. If necessary, providers can mail claims to Prevea360Health Plan, PO Box 56099, Madison, WI 53705 for payer ID 39113. For payer ID 41822 claims can be mailed to Medica – Prevea360, PO Box 211404, Eagan, MN, 55121.
- Coordination of Benefit (COB) claims must be received along with the primary payer's explanation of payment within the timely filing limit outlined in your agreement with Prevea360 Health Plan; beginning with the date noted on the primary payer's explanation of benefits. COB claims may also be submitted via electronic data interchange (EDI) on the 837 claims transaction. When submitting COB claims electronically, please include the prior payer's payment information in the relevant segments.
- Check the status of a claim through the Provider Portal Claim Status application or through the HIPAA-compliant 276/277 Health Care Claim Status Request and Response transaction.
- When a physician or a clinic becomes a "Contracted Provider," they agree to accept payment made by Prevea360 Health Plan as payment in full. Discounts and withholds are not to be billed to the member or the secondary insurance company. Members may be billed for copayments, coinsurance, deductible amounts, and non-covered services.

Failure to submit all required information could result in claim denials.

Acknowledgment of Submitted Claims

Prevea360 Health Plan offers acknowledgment of electronic claim submissions through the following:

- 277 Claims Acknowledgement (277CA) transaction
- Confirmation Reports Portal *only available for claims submitted under payer ID 39113

277 CA

Providers can sign up from the HIPAA Transactions page to receive 277CA responses for each electronic 837claim file submitted to the Health Plan. In the 277CA, each claim is identified individually as to whether it was accepted for processing or was rejected. Reasons for rejections are also supplied in the response.

Confirmation Reports Portal

The Confirmation Reports Portal is still an option to providers who sign up to receive 277CA responses. Confirmation reports show all claims successfully accepted for processing as well as all claims that were rejected and not accepted for processing. Confirmation reports are available within 48 hours of when Prevea360 Health Plan receives a claim. This includes claims submitted electronically or on paper.

Providers must contact their Provider Network Consultant to sign up for the Confirmation Reports Portal. Providers not signed up for the Confirmation Reports Portal will receive paper notification of claim rejections only. A link to the Confirmation Reports Portal can be found on the Account Login page on the Prevea360 website.

Providers should review each received Confirmation Reports Portal report, examples shown below, to confirm that all of their submitted claims were successfully accepted by Prevea360 Health Plan and to resolve the rejected claims. The rejected claims portion of the report will include error codes to explain the specific reason a claim was not accepted. Based on the error codes provided, please resubmit the claims with the necessary changes. **Providers are required to make corrections and resubmit the claim within the allotted time frame agreed upon in the contract beginning with the date of receipt.**

The following shows examples of the Confirmation Reports Portal for accepted and rejected claims:

Accepted

MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	RECEIVED DATE	CLAIM NUMBER	SOURCE	DOB
[redacted]	[redacted]	[redacted]	10/20/2016	1	164.00	12/01/2016	[redacted]	M	[redacted]

Rejected

MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	RECEIVED DATE	CLAIM NUMBER	SOURCE	REJECT REASON	DOB
[redacted]	[redacted]	[redacted]	11/10/2016	4	1034.00	12/01/2016	[redacted]	M	Member not on file.	[redacted]

For electronic claims submission, a 999 acknowledgement transaction will be used to indicate whether your transaction sets (ST/SE) passed SNIP types 1 and 2 compliance. Please work directly with your clearinghouse or EDI team to validate claim transaction acceptance. In cases of rejected 999s, please use the content of the transaction to understand the errors and resubmit the entire transaction.

For information about electronic claims enrollment and responses, go to the HIPAA transaction web page.

Correcting Claims

Prevea360 Health Plan recognizes that it is sometimes necessary to submit a corrected claim (e.g., changes or corrections needed to codes, dates of service, etc. due to error.

Steps for submitting a corrected claim:

1. Create a new claim with the corrected claim detail(s).
2. Include all lines billed on the original claim on the corrected claim.
3. Include the Claim Frequency Code ('7' for replacement claims) and the Payer Claim Control Number (original claim ID).
4. When replacing/deleting original procedure code, send the original billed code in the 2300 loop.
5. Add a note in the NTE segment (Box 19) about what has been changed from the original claim.
6. Submit the corrected claim using the same submission method of the original claim.

If a provider disagrees with the denial determination the claim can be appealed. Please see the Provider Appeals section of the manual for further details.

The scenarios in the following tables explains specifically which information is required.

Scenario #1: Corrected Claims - Not Requiring Supporting Documentation

	General Rule	**837P & 837I**	**CMS-1500**	**CMS-1450**
Claim Frequency Code	Must include one of the following: • '7' - Replacement • '8' - Void *Note: Corrected claims submitted with a '1' will be denied as duplicates.*	Loop 2300: CLM05-3	Box 22 – Resubmission Code and/or Original Reference Number	Box 4 – Type of Bill *Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted.*
Payer Claim Control Number	Must include the original Prevea360 Health Plan claim number associated with the correction. *Note: Corrected claims without a Prevea360 Health Plan formatted original claim ID will be rejected.*	Loop 2300: REF*F8	Box 22 – Resubmission Code and/or Original Reference Number	Box 64 – Document Control Number

Scenario #2: Corrected Claims – Requiring Supporting Documentation

Supporting documentation may still be required for certain claim-edit denials related to code bundling, new patient visits, global surgery, diagnosis, unlisted codes, etc.

Submitters must only submit claims requiring supporting documentation via the CMS-1450 or CMS-1500 form, using version 02/12. No electronic processing of these claims is currently supported. While Prevea360 Health Plan can accept the PWK segment on an 837 transaction, we cannot guarantee it is being used in claims processing.

In addition, submitters must complete a Code Review Request Form along with any additional, required supporting documentation. In order to abide by HIPAA guidelines, only documentation pertinent to the correction should be submitted.

	General Rule	CMS-1500	CMS-1450
Claim Frequency Code	Must include one of the following: • '7' - Replacement • '8' – Void *Note: Corrected claims submitted with a '1' will be denied as duplicates.*	Box 22 – Resubmission Code and/or Original Reference Number	Box 4 – Type of Bill *Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted.*
Payer Claim Control Number	Must include the original Prevea360 Health Plan claim number associated with the correction. *Note: Corrected claims without a Prevea360 Health Plan formatted original claim ID will be rejected.*	Box 22 – Resubmission Code and/or Original Reference Number	Box 64 – Document Control Number

Timely Filing Guidelines for Initial Submission

The initial submission of a claim is subject to the timely filing guidelines outlined in your agreement with Prevea360 Health Plan.

If a claim is rejected for improper submission, resubmission must be completed by the provider within the filing limit outlined in your agreement with Prevea360 Health Plan.

When applicable, retain 277CA files or confirmation reports from Prevea360 Health Plan in the event that you need to file an untimely filing waiver request**. Please be aware that when a provider fails to submit a claim timely, rights to payment from Prevea360 Health Plan are forfeited and the provider may not seek payment from the member as compensation for these covered services.**

Exceptions to Timely Filing Guidelines on Initial Claim Submission

- Requests for temporary waiver of the timely filing limit must be made **in advance** due to system conversions or other short-term circumstances. Such requests may be made, in writing, to your assigned Provider Network Consultant.
- If the provider had difficulty obtaining Prevea360 Health Plan coverage information from the subscriber, claims must be received within the timely filing limit beginning with the date the Prevea360 Health Plan coverage is identified, but not longer than 180 days from the date of service. Provider shall submit supporting documentation to demonstrate measures the provider has taken to obtain this information. Upon receipt of such information, provider must submit claims and supporting documentation within the filing limit outlined in their agreement.
- Claims for prenatal visits, which would have been normally billed as part of a global obstetrics (OB) charge, must be billed separately due to a change in physician and need to be submitted within timely filing limit, beginning with the date of delivery. Prevea360 Health Plan will not accept a global obstetrical charge from a provider.

Timely Filing Guidelines for Claim Resubmissions/Corrections

All resubmitted/corrected claims need to be received by Prevea360 Health Plan within the filing limit outlined in your provider agreement. The first day of the filing limit for resubmissions/corrections begins with the date upon which Prevea360 Health Plan notifies the provider a claim has failed processing or was denied. You will find this date on the Explanation of Payment (EOP) or your 835 Health Care Claim Payment/Advice transaction.

Exceptions to Timely Filing Guidelines on Claim Resubmissions

- Resubmitted claims as a result of our error can be resubmitted/corrected up to one year after the run date of the Rejected Claims Reports or the EOP date.
- If the provider has hospital-based providers (radiology, anesthesiology, etc.) or is submitting claims for a hospital-based provider who must wait for the inpatient discharge of the member, the provider must submit claims within

the timely filing limit from the discharge date of the inpatient confinement for Prevea360 Health Plan to consider payment.

- The provider discovers new or additional information and requests additional payment on a processed and paid claim. Provider must submit this information within the timely filing limit in order for Prevea360 Health Plan to consider additional payment.
- Newborn claims must be received no later than 14 months from the date of birth.

Explanation of Payment

Prevea360 Health Plan produces Explanation of Payments (EOP) information on a weekly basis. Providers are encouraged to receive remittance information electronically free of charge through the Prevea360 Health Plan Provider Portal for payer ID 39113 for claims processed prior to February 9, 2024 or our Health Care Claim Payment/Remittance Advice (835) transaction. For claims processed after February 9, 2024 for payer ID 39113 and for Payer ID 41822 providers can review EOPs through Instamed.

PAYMENT ADJUSTMENTS

When either Prevea360 Health Plan or a provider determines that payment has been made for services for which payment should not have been made, the provider should promptly return such overpayments to Prevea360 Health Plan. Upon the discovery of any such overpayments, Prevea360 Health Plan may alternatively offset such overpayments against any amounts otherwise due or thereafter becoming due from Prevea360 Health Plan as in the terms of your provider agreement.

The offset adjustments are made to the provider's claims in Prevea360 Health Plan's claims processing system. These adjustments will appear on the EOP following the processing of a provider's claims. Adjustments will be on the EOP in the "negative" (-) adjustment field.

The negative adjustments deduct payments from the provider's future claims. Overpayments may be taken from the same EOP as the adjusted claims appears or may be on future EOPs. Prevea360 Health Plan will continue to offset the negative amount on a provider's future claims until the overpayment is satisfied.

CLAIMS CODING PROCESS

Claims Coding

Prevea360 Health Plan is committed to processing claims in a consistent, timely, and accurate manner. To support this ongoing effort, claims processing logic is maintained to support the application of correct coding principles and Health Insurance Portability and Accountability Act (HIPAA) code-set standards. These payment policies are derived from recommendations from a variety of clinical and coding sources including, but not limited to:

- American Medical Association (AMA) correct coding principals
- Centers for Medicare and Medicaid (CMS) medical and coding policies including local and regional Coverage Determinations
- Nationally recognized academy and society guidelines
- Manufacturer's package inserts (FDA approved indications) for injectable drug and biologic agents

Code Review Request

If, after review, a provider believes their claim is coded correctly and that the charge was denied in error, they have the option to request a coding review via the Health Plan's Claim Review process.

To submit electronically:

- Complete the Claims Review Request form available in the Claim Appeals application of our Provider Portal at ProviderAuth.Prevea360.com.
- Include a brief, but detailed statement indicating why the decision should be overturned along with relevant supporting documentation (operative reports, medical records, etc.).

To submit via paper:

- Complete the Claims Review Request form available in our Document Library.
- Include a brief statement indicating why the decision should be overturned along with relevant supporting documentation (operative reports, medical records, etc.).

Please call the Customer Care Center at the phone number on the member ID card with questions.

PROVIDER CLAIM APPEALS

PROVIDER APPEALS PROCESS

If Prevea360 Health Plan denies a claim or benefit that results in a partial payment, denial to a practitioner, or makes a determination that is unsatisfactory to the practitioner, the practitioner of care is entitled to appeal the denial.

Appeal requests must be submitted in writing to be considered by an appropriate representative of Prevea360 Health Plan and should be submitted using the Claim Appeals Application in the Prevea360 Health Plan Provider Portal for efficiency. This instruction applies to appeals filed both for claims submitted under payer ID 39113 and payer ID 41822, as the application in the health plan provider portal will apply to both. Decisions are communicated in writing to the requesting provider specifying the reason(s) for the decision and advising the provider of their subsequent appeal rights should they be dissatisfied with the decision made by the Prevea360 Health Plan representative.

The results of the final review shall be considered final and binding upon Prevea360 Health Plan and provider.

TIMELY FILING APPEALS

If a claim is specifically denied for timely filing, the provider may appeal the timely filing denial. The provider must submit additional documentation to support that their claim was filed according to timely filing guidelines and/or exception guidelines in order for it to be reviewed by Provider Network Services.

The Provider Network Consultant will communicate the decision in writing to the requesting provider, specifying the reason(s) for the decision and advising the provider of their right to discuss the decision. The Provider Network Consultant shall have the right to uphold or overturn a timely filing denial, based on the documentation provided and final review. The results of the final review by Provider Network Services shall be considered final and binding upon Prevea360 Health Plan and the provider.

PROVIDER PORTAL APPEALS

Claims that have been processed with a finalized status (denied-paid) can be appealed online through the Prevea360 Health Plan Provider Portal or via paper submission. In-network providers are encouraged to submit claim appeals electronically through the Claim Appeals application of the Provider Portal.

Claim Appeal Types

- **COB**
  This appeal type is used to request reconsideration of a coordination of benefits (COB) denial. The primary payer's explanation of payment (EOP) is required if not submitted with the original claim.
- **Additional Payment**
  This appeal type is used to request reconsideration of a Prevea360 Health Plan payment. Include both the amount originally paid as well as the expected payment amount. A brief statement explaining why the original payment is incorrect is also required.
- **Recoup**
  This appeal type is used to request a recoupment or refund. Include both the amount originally billed as well as the recoupment/refund amount. The reason for the recoupment/refund is also required.
- **Timely Filing**
  This appeal type would be used to request reconsideration of a timely-filing denial. Providers are required to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. Documentation to support the timely filing appeal request is required.

- **Code Review Request**
  This appeal type is used to request reconsideration of a claims-edit denial. Denials may include frequency/maximum units, code bundling, inappropriate modifier, global surgery and diagnosis. A brief statement explaining why the claim edit should be overturned and corresponding supporting documentation is required.

- **Authorization Appeal**
  This appeal type is used to request reconsideration of a failure-to-prior-authorize denial. A brief statement explaining why the denial should be overturned and corresponding supporting documentation is required.

- **Medical Necessity**
  This appeal type is used to request reconsideration of a medical-necessity denial. A brief statement explaining why the denial should be overturned and corresponding supporting documentation is required.

- **Unlisted Codes**
  This appeal type is used to request reconsideration of an unlisted code denial. A description of the unlisted procedure, a brief statement explaining why the unlisted code denial should be overturned, and supporting documentation is required.

UTILIZATION MANAGEMENT

Failure to follow **Prevea360 Health Plan's** Utilization Management guidelines may result in claim payment denials or reimbursement of a claim at a lesser benefit. Because Prevea360 Health Plan has multiple products and benefits, some Prevea360 Health Plan benefit plans may require authorization for some services, while others may not. As such, the guidelines contained in this section are general and should be confirmed. Verify a member's benefits via the Eligibility functionality available on the Provider Portal at ProviderAuth.Prevea360.com, for payer ID 39113 and the Availity Essentials Portal for payer ID 41822, confirm the authorization requirements as noted in the member's certificate of benefit , and consult the Prevea360 Health Plan Medical Policies.

Utilization Management Hours of Operation

Prevea360 Health Plan staff is available to members and providers seeking information through the Customer Care Center at the phone number on the member ID card from 8:00 A.M. to 5:00 P.M. (CST) Monday through Friday, except for recognized national holidays (e.g., Labor Day, Memorial Day, Christmas Day, etc.) The Customer Care Center is the first contact for general inquiries; however, callers with questions regarding specific utilization management matters that cannot be addressed by the Customer Care Center are directed to Utilization Management staff by the Customer Care Center.

Utilization Management staff is available via voice message outside the standard business hours and will contact the requester within one business day of receipt of the request of the voice message, provided the voice message contains the requester's return contact information.

Members may access Pevea360 Health Plan via a toll-free number to the Member Services Department or via a toll-free number to the Utilization Management Department. The Customer Care Center handles general inquiries, but callers with questions that cannot be addressed by the Customer Care Center regarding specific Utilization Management decisions are directed to Utilization Management staff by the Customer Care Center. Utilization Management staff identifies themselves by name, title and the organization when receiving or initiating calls to providers regarding Utilization Management issues.

Access to TTY/TDD services are available to the members via the Telecommunications Relay Service (TRS) number of 711 which is communicated via any correspondence provided to the member from the Utilization Management Department. Translation services are also available to members and providers through a collaborative process between the Customer Care Center and the Utilization Management Department.

AUTHORIZATIONS

A prior authorization is a written request submitted to the health plan by an in-network primary care provider or in-network specialist requesting authorization approval of a specific service(s) with another in-network provider or, in some cases, an out-of-network provider. An approved prior authorization is required when a service is indicated in a Prevea360 Health Plan Medical Policy as requiring prior authorization, when a rendering provider is out-of-network, or the service is an elective in-patient admission. As you review the information below, please note that while the health plan transitions business platforms, submission methods for authorization review may change according to payer ID and provider portal status.

High-Quality, Cost-Effective Care Through Authorization

Prevea360 Health Plan's goal is to provide high quality, cost-effective care, at the right time and in the right setting for members. The UM Department maintains processes to ensure: (a) equitable access to care across the network and (b) the most appropriate use of medical services in accordance with member benefit coverage. The health plan achieves this through our contracts with in-network providers and our Utilization Management Program by monitoring authorizations. and through ongoing evaluation.

The scope of UM activities includes, but is not limited to, the following major categories:

- Authorization management through prior authorization, concurrent review, retrospective review and evaluation/discharge planning
- Monitoring quality of care through clinical indicators and service satisfaction obtained from provider and member surveys
- Quality assurance monitoring and tracking and follow-up of sentinel events and quality of care issues is accomplished through the review process and regular meetings of the Medical Peer Review Committee.

Refer to the Prevea360 Health Plan Medical Management page for services requiring prior authorization and their specific requirements.

Prior Authorization
A request submitted by a provider for approval of services before they are rendered. This authorization type is sometimes referred to as an initial authorization request or pre-service authorization request.

Concurrent Authorization
Authorizations submitted by a provider for a member who is receiving ongoing care. Concurrent authorizations are generally related to members who are inpatient in a hospital or skilled nursing facility (SNF) and are actively receiving services at the time the authorization request is made.

Post-Service Authorization
Post Service authorizations are authorizations that are submitted after a member's care has been received or completed. Post-service authorizations are only considered for coverage in limited and specific circumstances given that authorization policy is based on a provider obtaining written authorization approval ***prior*** to services being rendered.

AUTHORIZATION INFORMATION AND RESOURCES

Formal Approval
Prior authorization approval is written documented approval from the health plan's Utilization Management Department, or in some cases for certain services from one of the health plan's authorization vendors. A verbal or written request for services does not constitute an approved prior authorization. A prior authorization request does not guarantee payment of services received.

Online Authorization Resources
Providers can access the health plan's authorization requirements in specific medical policies and the Prevea360 Health Plan Master Services List (MSL), both accessible from the Prevea360 Health Plan Medical Management page. If a service is not found in a medical policy or listed in the MSL, providers are encouraged to also refer to the Prevea360 Health Plan Non-covered Medical Procedures and Services list, also accessible from the Prevea360 Health Plan Medical Management page, to verify the service is not on that list.

In-Network Providers
For most products, only Prevea360 Health Plan in-network providers can submit authorization requests to the health plan. An in-network provider is one that is contracted with Prevea360 Health Plan to provide services and is listed in our provider directory. An out-of-network provider is either not contracted with Prevea360 Health Plan or is contracted differently than an in-network provider. Out-of-network providers are not listed in our provider directory. The health plan has no liability or responsibility for services provided by out-of-network providers without a contract with Prevea360 Health Plan.

In-network providers are responsible for completing and submitting an authorization request for an out-of-network provider when they believe that the request is medically necessary. The in-network provider who submitted the authorization request is also responsible for ensuring the approved prior authorization is in place prior to services being rendered.

Member Benefit Considerations for Authorizations

Approved authorizations indicate only that the service(s) are considered medically necessary. If a member's benefits have been exhausted or the requested service is not a covered benefit under the member's plan, the claim for the service will deny. The same is true if a member has a change in enrollment status and becomes ineligible for the service. In this case the claim will deny indicating that the member is not eligible for coverage.

SUBMITTING PRIOR AUTHORIZATION REQUESTS

Prior authorization requests should be submitted as soon as the determination is made to recommend or schedule a service. This facilitates determinations being made and communicated in advance of the member's scheduled date of service. Please note that processes for authorization submission may differ for members in plan types under payer ID 39113 and those under payer ID 41822. For payer ID 39113, please continue to submit authorizations via the Prevea360 Health Plan provider portal. For payer ID 41822, electronic submissions can be submitted via the Availity Essentials Portal.

If an authorization request is denied, a written denial for the requested services will always be provided to the member that includes the reason for the denial or redirection and appeal information. The provider who submitted the authorization request and the servicing providers are also notified of the denial or redirection via the Provider Portal, or in writing if access to the Provider Portal is not available to the provider(s). The member and the provider make the final decision regarding whether the member will receive any services, despite a denial from the health plan. Authorizations can be submitted through the health plan provider portal for payer ID 39113, and through the Availity Essentials provider portal for members under payer ID 41822. Interim processes, as necessary, will be announced and detailed on the Provider Communications page.

Electronic Authorization Submissions

Providers with Provider Portal access are strongly encouraged to submit authorization requests electronically through the Provider Portal. Authorization requests for most services can be submitted through the secure Prevea360 Health Provider Portal Authorization Submission application for payer ID 39113. Our secure Provider Portal is a 24/7 direct line between your organization and our self-service applications to exchange electronic transactions. Additionally, the health plan sends an electronic response to authorization requests that come through the Provider Portal.. Refer to the Prevea360 Health Plan Provider Registration User Guide on the Account Login page for complete instructions on how to create an account.

For payer ID 41822 authorization request can be submitted through the Availity Essential Portal.

In the case of an unexpected outage, a paper request form may be faxed or email in for review, found on the Medical Management Page under Prior Authorization Forms and then General, which applies to both inpatient and outpatient service requests. Please be sure to fill out the form in its entirety, attach supporting documentation, and provide a dedicated contact for return messaging or follow-up. Faxed forms can be sent to 608-252-0830, or email at IFBHealthManagement@Medica.com. Emailed requests will receive an acknowledgement auto-response.

The Provider portal will indicate determination (approved/denied) and a letter will be sent to the member. If the request was submitted on the paper form, determinations will be sent to the provider via fax.

Paper Form Submission Guidelines

If your organization is not able to submit authorization requests electronically, they can be submitted on a paper Authorization Request Form and faxed to the Utilization Management Department at 608-252-0830. The health plan sends a written notification following receipt of the request. The member and servicing provider will both receive a response to the request via written correspondence.

Providers must follow the guidelines below when submitting a paper authorization request form:

- Submit the request using the applicable Prior Authorization Request Forms accessible from the Prevea360 Health Plan Medical Management page at Prevea360.com/For-Providers/Medical-Management.
- Authorization request forms should be mailed or faxed on the date the request has been completed to ensure timely processing of the authorization request.
- Complete **all** fields on the form in their entirety, otherwise the Utilization Management Department will return it to the submitting physician for completion.
- When an authorization is requested for the services of an out-of-network provider, include as much information as possible regarding why the request is being submitted and a list of in-network providers who the member has already seen. The Utilization Management Department will review these authorization requests to ensure that medically necessary care has been requested and that the services requested are not available with in-network providers. *Note*: Only services that are NOT provided within the Prevea360 Health Plan provider network are considered for approval with a non-contracted provider.
- Fax paper authorization requests to 608 252-0830 or mail to:

Prevea360 Health Plan
ATTN: Utilization Management
PO Box 56099
Madison, WI 53705

Use of Other Entities for Authorization Services

Prevea360 Health Plan contracts with other entities for the review and prior authorization of certain services. In these cases, prior authorization requests should be submitted to the contracted vendor, not Prevea360 Health Plan, as shown in the table on the next page.

Service	Whom to Submit	How to Submit
Pharmacy Benefit Drug Authorizations	Navitus/Navi-Gate	Authorization forms and submission through the Navitus Prescriber Portal at Prescribers.Navitus.com or via fax information on the form.
Medical Benefit Drug Authorizations	Prevea360 Health Plan	Authorization forms are available through the Navitus Prescriber Portal at Prescribers.Navitus.com, but should be submitted to Prevea360 Health Plan via the Health Plan Provider Portal or via fax, mail, or phone information on the form.
Medical Injectables * *For benefit classifications and submission information, see our Medical Injectables List.*	Prevea360 Health Plan (for Medical Benefit medications) or Navitus/Navi-Gate (for Pharmacy Benefit medications)	Authorization forms are available through the Navitus Prescriber Portal at prescribers.navitus.com. Submit Medical Benefit medications through the portal that corresponds with your member's plan type and payer ID, or via fax, mail, or phone information on the form. Submit Pharmacy Benefit medications through the Navitus Prescriber Portal or via fax information on the form.
Services/Procedures requiring authorization per Prevea360 Health Plan Medical Policies * *See our Master Service List to know if authorization is required and where and how to submit authorizations.*	Prevea360 Health Plan	For Payer ID 39113 providers can submit authorization request via the Prevea360 Health Plan Provider Portal. For Payer ID 41822 providers can submit authorizations through the Availity Essentials Portal. For both Payer ID's authorizations can be submitted via fax or email by using the authorization form available on the Medical Management page.
Radiology Prior Authorizations * *For more information, see our Radiology policies (NIA) web page.*	NIA Magellan	RadMD Portal
Musculoskeletal Authorizations (MSK) (inpatient hip and knee and inpatient and outpatient shoulder and spine surgeries) * *For more information, go to our Musculoskeletal) Program web page.*	NIA Magellan	RadMD Portal

SUPPORTING DOCUMENTATION

Providers must submit all relevant documentation along with the authorization request submission in order for Utilization Management Department to review and make a determination on the request. For payer ID 39113, providers can electronically attach supporting documentation when submitting their authorization requests through the Provider Portal. For payer ID 41822, supporting documentation can be emailed to ifbhealthmanagement@medica.com or faxed to 608-252-0830 regardless of submission type.

If an authorization request is submitted with insufficient information, the Utilization Management Department adheres to the following process to obtain missing documentation:

- A phone call is made to the provider office to request the additional information. Prevea360 Health Plan Utilization Management will advise of:
    - Member name and DOB
    - Specific authorization request that is missing information
    - Specific information which is required

    - Fax number and name of individual that the information should be made attention to
- If the requested information is **not** provided within the initially requested 2 business days, Utilization Management will contact the provider office again within 1 business day and advise of the following:
    - This is the second request for additional information
    - Date of the original request for information
    - Member name and DOB
    - Specific authorization request that is missing information
    - Specific information which is required
    - Fax number and name of individual that the information should be made attention to
- The provider will be advised that if the information is not received within the second new time frame, the authorization will be submitted to the Medical Director for review based on the information that is available on the first business day after the second requested time frame has ended.
- Authorization and any available information will be directed to the Medical Director for review no later than the first business day following receipt of the information or expiration of the second provided time frame.
- If the authorization is denied a **new** authorization request with new objective medical documentation must be submitted for consideration of the services. The required information **cannot** be provided via the peer-to-peer process for the authorization denial.
- Resubmission of an authorization request **must** contain **new** objective medical documentation for it to be considered. New authorizations should not be submitted simply to re-open the peer-to-peer process.
- Authorizations without new objective medical documentation will be cancelled back to the provider if entered through the Provider Portal or will not be entered if submitted on paper and the requesting physician office will be contacted to advise why the authorization is not being processed.

Tips for Submitting Prior Authorization Requests

Consider these tips when submitting a prior authorization request to Prevea360 Health Plan:

- For efficiency, consider these tips when submitting a prior authorization request to Prevea360 Health Plan. All of the tips below may not be relevant for your submission method. Use the provider information that populates from the portal, when possible.
    - If the provider information is not found in the portal and must be entered manually, Referring Providers should enter the address for the Servicing Provider only once and in the Addr 1: field. While there is an Addr 2 field, a second address is not required nor should the address from the Addr 1: field be entered again into that field. Always provide a contact name and phone number with the request in the Additional Information field in the portal or on the fax cover sheet.
- Note what is specifically being requested in the Additional Information field in the portal or on the fax cover sheet. For example: "Left L4 SNRB, please see notes from office visit on August 31, 2019."
- Include all relevant clinical documentation at the time of submission to prevent delays in the determination review.
- Include dates of office visits, previous procedures, etc. if relevant to the request; note any specific dates in the EMR and/or on the paper documentation that support the request. Refer to the Prevea360 Health Plan document library to review Health Plan Medical Policies. These documents outline the criteria being reviewed and will help to identify what documentation to submit along with the request.
- Indicate if this is a member request or a physician request. As examples:
    - "Request is for John Doe to continue services with ABC Transplant Services through December 31, 2021. Has current authorization to ABC Transplant through December 31, 2020. Kidney transplant on 6/15/2018. Please contact Mary Jones at 888-888-8888 for any questions related to this request. This is a physician request."
    - "Request is for Jane Doe to see Dr. Jones at XYZ Clinic Cardiology. This is a member request. Please see XYZ Cardiology note dated 12/1/2020 for additional information. Please contact Mary Jones at 888-888-8888 for any questions related to this request."

- "Request is for endovenous laser ablation (EVLT) of both right and left greater saphenous vein. See Vascular Surgery note dated 12/1/2020 and ultrasound report dated 11/15/2020 for additional information. Please contact Mary Jones at 888- 888-8888 for any questions related to this request."

CANCELLED PRIOR AUTHORIZATION REQUESTS

Not all services require prior authorization approval. If an authorization request is submitted when prior authorization is not required, the request is reviewed and a "Cancelled" determination status is applied. Prevea360 Health Plan offers a variety of resources to help providers determine when prior authorization is required and where to submit the request:

- Check the Master Service List (MSL). In addition to listing policies and services that do require authorization, the MSL also includes a number of services that do not require prior authorization, denoted in the purple-colored sections.
- Check the Document Library to search for specific policies.
- Check the Medical Injectables List for commonly prescribed drugs and whether prior authorization is required.

Check the Non-covered Services List if you can't find the service in any of the above resources.

AUTHORIZATION STATUSES AND PRIORITY DEFINITIONS

Authorization Priority

In compliance with NCQA requirements and state law, Prevea360 Health Plan adheres to specific time frames for authorization determinations.

The authorization status refers to the urgency with which the authorization requires processing. This is a required field for authorization entry. There are six authorization statuses; two are specific to inpatient authorizations and four are specific to outpatient authorizations.

INPATIENT AUTHORIZATION STATUSES	OUTPATIENT AUTHORIZATION STATUSES
• Urgent Admission • Elective Admission	• Pre-service Non-Urgent • Post service • Pre-service Medically Urgent:(Refer to the definition of pre-service medically urgent in the table below.) • Pre-service Administratively Urgent *(not available for payer ID 41822)

Authorization Priority Definitions

AUTHORIZATION STATUS	TIMEFRAME	DEFINITION	STATUS TYPE
Pre-service non urgent	Determination and notification within 15 calendar days of receipt.	This status is used for outpatient requests.	Outpatient
Urgent admission	Notification within 24 hours of request recipt of determination or need for additional documentation. Notification will not exceed 72 hours of request recipt.	This status is used for inpatient admission to a facility when the member is admitted from either the emergency room, an observation status or a physician office.	Inpatient
Elective Admission	Provider notification at least 7 calendar days prior to scheduled elective admission. Determination within 15 calendar days of receipt.	This status is used for elective inpatient admissions to a Hospital or Skilled Nursing Facility	Inpatient
Post-Service	Determination within 30 calendar days of receipt (unless additional information is required for determination).	This status is used for requests that are received after the member's services have already been received. Most post-service requests will not be accepted. Exceptions will only be considered that initiate over a weekend or holiday.	Outpatient
Pre-Service Medically Urgent	Determination and notification within 72 hours of receipt.	This status is used for requests when the delay of service could jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without this care or treatment.	Outpatient
Pre-Service Administratively Urgent *(not available for payer ID 41822)	Determination and notification as prompt as possible with a goal of within 7 calendar days but may be up to 15 calendar days.	This status is used for requests that do not meet the definition of Medically Urgent, however, are deemed to be time-sensitive by one or more of the affected parties due to appointments scheduled within the 15 calendar day determination time frame.	Outpatient

PEER-TO-PEER REVIEW PROCESS

The peer-to-peer review process offers the requesting provider an opportunity to discuss the denial determination of an authorization request with a Prevea360 Health Plan Medical Director. It is NOT considered a provider authorization appeal. The peer-to-peer review process is intended to give the requesting physician an opportunity to discuss the denial determination when they believe that the submitted documentation supported an approval determination. A request for a peer-to-peer review can be initiated by calling the UM department at 800-356-7344 ext. 4795. This information is also included in the denial determination notice.

The peer-to-peer review process should not be used as a means for the provision of additional information that should have been provided with the initial authorization request. All applicable medical documentation should be provided or available to Prevea360 Health Plan UM when an authorization is originally submitted for review and/or a determination is in progress. If additional objective medical information is obtained following the denial determination a new authorization request must be submitted with that additional information. New authorization requests submitted without additional objective medical information will not be accepted.

The opportunity for a peer-to-peer review is available for up to ten calendar days after the denial determination has been made. Alternatives to consider if the ten-calendar day window has elapsed include filing a formal provider appeal or directing the member to the appeals and grievance process outlined in their letter; member benefit certificate or by contacting the Prevea360 Health Plan Customer Care Center at the phone number listed on the member's ID card.

AUTHORIZATION APPEALS

Prevea360 Health Plan providers can appeal medical necessity denial determinations through the health plan's appeals process. We strongly recommend that providers complete the peer-to-peer review process before submitting a provider authorization appeal as resolution may be reached with a verbal discussion between the physician provider and a Prevea360 Health Plan Medical Director through that process.

Prevea360 Health Plan members may file an appeal or grievance relating to any aspect of the health plan by following the formal grievance procedure outlined in their member certificate. The Member Services Department is responsible for the research and resolution of the grievance.

PRIOR AUTHORIZATION GUIDELINES

Because Prevea360 Health Plan has multiple products and benefits, some Prevea360 Health Plan benefit plans may require authorization for some services, while others may not. As such, the overview guidelines contained in this section are general and should not be construed as a description of coverage for members. Verify a member's benefits via the Eligibility functionality available on the Provider Portal at Prevea360.com/Tools-and-Resources/Account-Login for payer ID 39113, and Availity Essentials for payer ID 41822. Confirm the authorization requirements in the member's Certificate of Coverage, and consult the Prevea360 Health Plan Medical Policies.

Furthermore, some of the Prevea360 Health Plan clinical guidelines used by the Health Services Division, such as the MCG Care Guidelines are accessible to the provider upon request. Contact the Customer Care Center at the phone number on the member's ID card to request clinical guidelines.

HMO AUTHORIZATION GUIDELINES

Prevea360 Health Plan requires members who are enrolled in an HMO benefit plans choose a primary care provider/clinic. The primary care provider acts as a "gatekeeper" to ensure members receive appropriate, high-quality care in a cost-effective manner. Primary care practitioners (and sometimes plan specialists) should assist members by completing and submitting an authorization request for an out-of-network provider when they believe that the request is medically

necessary. Prevea360 Health Plan in-network providers are responsibility for authorization requests and ensuring that an approved prior authorization is in place prior to rendering services.

POS AUTHORIZATION GUIDELINES

Pevea360 Health Plan members enrolled in a POS benefit plan are not required to use in-network providers but may have lower out-of-pocket costs by using an in-network provider. Because POS members have the choice to use in-network or out-of-network providers, prior authorization for non-contracted services is not necessary unless required by Prevea360 Health Plan Medical Policy. They have the option to use in-network or out-of-network providers but may receive a different level of benefits based on the rendering provider's status within the indicated network. POS members may be subject to a prior authorization penalty if the authorization is not obtained prior to receipt of medically necessary services.

If a member seeks services from a non-contracted provider, the member is responsible for prior authorization requirements and may be subject to penalty or denial of services if prior authorization is not obtained before the services are received. Members who are obtaining their own prior authorization should contact the Customer Care Center at the phone number on the member's ID card for assistance.

POS IN-PLAN BENEFIT EXCEPTION POLICY

If medically necessary services are not available within Prevea360 Health Plan's provider network, services with out-of-network providers will be considered for coverage at the in-plan benefit level **only if**:

- A Prevea360 Health Plan in-network provider has submitted an authorization request on the member's behalf indicating that they are requesting services at the in-plan benefit level because they are not available in-network.

and

- The request has been reviewed and approved for in-plan benefits by the Prevea360 Health Plan Utilization Management Department **prior** to the delivery of the services.

Authorization requests will be cancelled if all the following criteria are met:

- for out-of-network providers for services that do not require an authorization
- the request does not indicate that the prior authorization request is being made specifically for in-plan benefits.

Authorization requests will be denied to out-of-network providers requesting in-plan benefits when the services are available with in-network providers. The denial will indicate that the in-plan benefit level of payment has been denied and the in-network provider who can deliver the requested service.

POS In-Network Benefit Exception Policy

If medically necessary services are not available within Prevea360 Health Plan's provider network, services with out-of-network providers will be considered for coverage at the in-plan benefit level **only if**:

- A Prevea360 Health Plan in-network provider has submitted an authorization request on the member's behalf indicating that they are requesting services at the in-plan benefit level because they are not available in-network.

  and

- The request has been reviewed and approved for in-plan benefits by the Prevea360 Health Plan Utilization Management Department **prior** to the delivery of the services.

Authorization requests will be cancelled if all the following criteria are met:

- for out-of-network providers for services that do not require an authorization
- the request does not indicate that the prior authorization request is being made specifically for in-plan benefits.

Authorization requests will be denied to out-of-network providers requesting in-plan benefits when the services are available with in-network providers. The denial will indicate that the in-plan benefit level of payment has been denied and the in-network provider who can deliver the requested service.

PPO Authorization Guidelines

Prevea360 Health Plan members enrolled in a PPO benefit plan are not required to use in-network providers but may have lower out-of-pocket costs by using an in-network provider. Members enrolled in PPO plans have access to nationwide networks of providers. Because PPO members have the choice to utilize in-network or out-of-network providers, prior authorizations for out-of-network services are not necessary unless required by the Prevea360 Health Plan Medical Policy. Prevea360 Health Plan Utilization Management does not authorize services for these members for in-network or out-of-network benefit levels of payment. Claims for services will be processed based on the rendering provider's affiliation or lack of affiliation with the PPO network in which the member is enrolled.

MEDICAL MANAGEMENT

The following pages contain an overview of some common services designated by the outpatient- "OUTPATIENT/AMBULATORY CARE SERVICES" or inpatient- "HOSPITAL ADMISSIONS AND CONCURRENT REVIEW PROCESS" nature of the service. These descriptions are intended to provide only an overview of when a provider should seek authorization through Prevea360 Health Plan and the guidelines by which to do so. This information should not be used as a description of specific coverage for members. When reviewing this section, please also refer to the online Prevea360 Health Plan medical management information and other resources, listed below, to navigate the health plan policies, requirements, and member coverage.

Access

- Prevea360 Health Plan Medical Management web page by following these step-by-step instructions:
    1. Go to the Prevea360 Health Plan home page at Prevea360.com.
    2. Hover over the **Providers** link at the top of the web page
    3. Select the **Medical management** home link under Medical Management.

Resources and Requirements

- Once on the Prevea360 Health Plan Medical Management page, access the following:
    - **Medical Prior Authorization Service List**— Also referred to as the Master Service List (MSL),. lists medical policies with links, prior authorization requirements and applicable coverage limitations, as well as information for some services that do not require authorization. When authorization is required, submission method information about where and how to submit authorizations is also listed.
    - Medical Injectables List — A list of drugs that are covered under the medical benefit available from the Pharmacy Services web page.
    - **Medical and Drug Policies**. Prevea360 Health Plan policies are reviewed at least annually and updated based on technology assessment resources and in-network provider feedback.
    - **Prior authorization forms** for certain services to be used by those providers without the ability to submit authorization requests electronically through the Prevea360 Health Plan Provider Portal.
    - **Prior Authorization web pages** detailing certain services, including, but not limited to:
        - Radiology — Prevea360 Health Plan contracts with NIA/Magellan for authorization of high-end radiology services. Authorization requests for high-end radiology should be submitted through the NIA Magellan portal linked from our Account Login page.
        - Musculoskeletal (MSK) Care Management Program — Prevea360 Health Plan contracts with Magellan Healthcare for review and authorization of non-emergent MSK: inpatient hip and knee and inpatient and outpatient shoulder and spine surgeries. Authorization requests for MSK services should be submitted through the NIA Magellan portal linked from our Account Login page.
- **Member benefit plan information (for payer ID 39113 only)** — Access online member health plan benefit information, including certificate of coverage, member policy or certificate at MemberBenefits.Prevea360.com by entering the full member ID or group number. *(Note*: You must use Google Chrome to access this page.)
- **Customer Care Center** — Call the phone number on the member ID card with questions about policies, authorization requirements, member coverage, or the maximum number of visits in a member's certificate.

OUTPATIENT/AMBULATORY CARE SERVICES

AUTISM SERVICES

Prevea360 Health Plan covers services in accordance with the Wisconsin Autism Mandate.

Providers can render and bill autism treatment services that are medically necessary per the state mandate without a prior authorization if the primary diagnosis on the claim is a recognized autism diagnosis. For successful claim adjudication, the primary diagnosis must be a recognized autism diagnosis for the rendered service to be eligible for coverage without a prior authorization. If the service is for a primary diagnosis other than a recognized autism diagnosis, the service is subject to prior authorization requirements.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE – OUTPATIENT

Prevea360 Health Plan provides coverage of mental health and substance abuse treatment for those members whose benefit package includes mental health/substance abuse services with an approval authorization from the health plan. For providers without Portal access, authorization requests may be faxed to 608-252-0830. All services must be medically necessary.

Outpatient Behavioral Health and Substance Abuse

Some outpatient services require prior authorization to determine medical necessity. These include, but may not be limited to:

- Outpatient care with an out-of-network provider, including group, family, and individual therapy

See Prevea360 Health Plan's Behavioral Health Provider Annual Training created specifically for in-network Behavioral Health providers. These brief training slides, available from the Behavioral health prior authorization web page, highlight behavioral health medical policies and prior authorization information.

OUTPATIENT SURGERY/OUTPATIENT PROCEDURE

Definitions of Surgical Day Care Services And Ambulatory Surgery Center (ASC)

Surgical Day Care Services (SDC)/Surgical Day Care with Overnight (SDCON) are services generally more invasive than ambulatory/minor surgery and usually require incision or excision procedures. General anesthesia and recovery room services are frequently required. SDC services are usually performed either in a hospital setting or ambulatory surgical center (ASC) and can frequently require an overnight stay (not expected to exceed 23 hours post procedure) as part of the recovery period.

Note: members who do not have an acute medical need which meets inpatient medical necessity criteria guidelines **cannot** be admitted as an inpatient status either prior to or following 23 hours of post procedural care.

SDC/SDCON procedures that are converted to an inpatient admission due to an unforeseen complication and meet inpatient criteria guidelines are considered urgent/emergent and require authorization as outlined in the Urgent/Emergent Inpatient Admission section of this manual

- **Ambulatory/Minor Surgery Service (ASC)** are surgical services that usually do not require general anesthesia or extended recovery room time and the member is expected to be discharged home that same day.
- **Outpatient Surgery/Outpatient Procedures** are services that usually do not require general anesthesia or extended recovery room time and the member is expected to be discharged home that same day.

Some outpatient procedures require authorization prior to the services according to Prevea360 Health Plan Medical Policy. If the service requires an authorization, providers are responsible for obtaining an approved authorization **prior** to the services being received.

Providers with Provider Portal access to authorizations **must** submit the required information through the Provider Portal. All providers without Provider Portal authorization access have two options to provide the required admitting information:

- Fax the required information to 608-252-0863
- Phone the required information to 800-356-7344

The applicable medical policy for the service being requested should be reviewed prior to submission of an authorization. Refer to the Medical Policies on the Medical Management web page.

EMERGENT AND URGENT CARE SERVICES

Emergent/Emergency Care

An emergency medical condition is one brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or part.
- Inadequately controlled pain.
- With respect to a pregnant woman who is having contractions:
  - Inadequate time to complete a safe transfer to another hospital before delivery; Or
  - A transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency services are covered services given by any qualified provider, and are services needed to evaluate or stabilize an emergency medical condition. A prior authorization is not required for emergency services.

Emergency Care from Prevea360 Health Plan Providers

Most of the time, members will get emergency care from a Prevea360 Health Plan in-network provider. If members are unable to reach an in-network provider, they should go to the nearest medical facility to receive care.

Emergency Care from Out-of-Network Providers

If your patient must go to an out-of-network provider for emergency care, call the Customer Care Center at the phone number on the member's ID card as soon as possible after they have received care to notify us where they received emergency care. A prior authorization is not required for emergency care services. Applicable emergency room copayments apply whenever emergency services are received at an emergency room.

Non-emergent/non-urgent follow up care with an out-of-network provider is not covered unless this care is prior authorized by the Prevea360 Health Plan Utilization Management Department.

Urgent Care

Urgent care is care that is needed sooner than a regular physician's office visit (ex. broken bones, sprains, minor cuts and burns, drug reactions, and non-severe bleeding). A prior authorization is not required for services in an urgent care setting.

Urgently Care from In-Network Providers

If the member is in the Prevea360 Health Plan in-network service area and has a sudden illness or injury that is not a medical emergency, the member should call their primary care provider. Prevea360 Health Plan expects members receive urgent care from in-network providers. In most cases, Prevea360 Health Plan will not pay for urgently needed care that a

member receives from an out-of-network provider while the member is in the Prevea360 Health Plan in-network service area.

Urgently Care from Out-of-Network Providers

Authorization is not required for services provided in an urgent care center. If the member is outside of the service area, the member should call their primary care provider or the 24-hour nurse access line to see if their condition needs immediate attention. Urgent care should be received at the nearest appropriate medical facility unless the member can safely return to the in-network service area to be seen by their primary care provider.

There are no available benefits for follow-up care with an out-of-network provider unless such care is necessary to prevent further health risks. **Such care must be prior authorized through the Prevea360 Health Plan Utilization Management Department**.

The aforementioned guidelines do not apply to Prevea360 Health Plan PPO/POS members; they are not required to use Prevea360 Health Plan policy providers for coverage of services.

NEW TECHNOLOGIES

Procedures not commonly accepted as a standard of care within the health profession are not a covered benefit of the member's plan.**.** New technology services are reviewed by the Prevea360 Health Plan Health Services Division for medical appropriateness and efficacy by the Prevea360 Health Plan Medical Directors. Updated information about new technology assessments, when determined, is published in editions of the monthly Prevea360 Health Plan *Provider News*.

CHIROPRACTIC CARE

Prevea360 Health Plan provides coverage for chiropractic care when provided by an in-network provider with the exception of long-term and maintenance therapy. Prevea360 Health Plan POS members are not required to use in-network providers.) For emergent/urgent chiropractic care by an out-network provider, refer to emergent and urgent care services in this section. A prior authorization request from a member's primary care provider is not required in order to see an in-network chiropractor. If you need further assistance in understanding chiropractic benefits, contact the Prevea360 Health Plan Customer Care Center at the phone number on the back of the member ID card.

Therapy Types

- **Active Therapy —** regular care with an established patient to resolve a particular ailment. An AT modifier is required for Active Therapy and must be in the first modifier position.
- **Long-Term Therapy —** therapy extending beyond two months that is determined, by our Medical Affairs Division, to be primarily maintenance therapy.
- **Maintenance Therapy** — ongoing therapy delivered after the acute phase of an accident or illness has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "maintenance therapy" is made by the health plan after reviewing an individual's case history or treatment plan submitted by a health care provider.

The determination of what constitutes "maintenance/long-term therapy" is made by the chiropractor. Prevea360 Health Plan will review the case history or treatment plan of the patient if a questionable situation would arise. When a member reaches long-term/maintenance therapy, providers can give them a copy of the "Chiropractic Handout for Prevea360 Health Plan Members" on the next page of this manual. This is designed to give members a brief description of benefits that are not available for long-term/maintenance therapy.

CHIROPRACTIC HANDOUT FOR PREVEA360 HEALTH PLAN MEMBERS

Prevea360 Health Plan covers chiropractic services when they are provided by a Prevea360 Health Plan in-network provider to a Prevea360 Health Plan member with applicable coverage. As a Prevea360 Health Plan member, we encourage you to refer to your benefit certificate to determine your coverage and see if you are required to pay an office copayment each time you visit your chiropractor. Also, check your benefit certificate to see if items supplied by your chiropractor are covered under your member benefit.

Examples of covered supplies include:

- Slings
- Rib Belts
- Lumbar-sacral orthosis
- Wrist Cock-up Splint
- Cervical Collars
- Sacroiliac Support
- Elbow Orthoses
- Air Cast

Examples of non-covered supplies include orthopedic pillows, cushions, and other convenience items.

Services not covered for chiropractic care:

- Long-term and/or maintenance therapy
- Chiropractic care (non-urgent/emergent) provided by an out-of-network chiropractor (unless you are enrolled in a Prevea360 Point of Service (POS) or Preferred Provider Organization (PPO) health plan.

Prevea360 Health Plan provides coverage for chiropractic care with an in-network provider with the exception of long-term and maintenance therapy, as described below. If you are enrolled in a Prevea360 Health Plan benefit plan that also offers a Point of Service benefit, you are not required to use in-network providers.

- **Long-Term Therapy** – means therapy extending beyond two months which is determined, by Prevea360 Health Plan, to be maintenance therapy.

- **Maintenance Therapy –** means ongoing therapy delivered after the acute phase of an illness or injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated.

The determination of what constitutes "maintenance therapy" is made by the chiropractor and/or Prevea360 Health Plan Health after reviewing an individual's case history or treatment plan submitted by a provider of health care.

Services are **not covered** if you seek chiropractic care with a provider who is out of the Prevea360 Health Plan network, unless it is urgent or emergent.

We are here to help! If you need assistance in understanding chiropractic benefits or have questions, please call the Prevea360 Health Plan Customer Care Center at the phone number on the member's ID card..

HOSPITAL ADMISSIONS AND CONCURRENT REVIEW PROCESS

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES– INPATIENT

Prevea360 Health Plan manages behavioral health services for all members who have behavioral health benefits. For providers without Portal access, authorization requests may be faxed to 608-252-0843C. All services must be medically necessary.

Inpatient Behavioral Health and Substance Abuse

- For urgent/emergent inpatient hospital admissions, a prior authorization is not required. However, the admitting facility must notify Prevea360 Health Plan of the admission within 48 hours or whenever it is medically feasible (whichever is longer).
- Prior authorization is required for all elective or non-emergency inpatient and residential treatment center stays *before* admission.

URGENT/EMERGENT INPATIENT ADMISSION NOTIFICATION

In-network hospitals are responsible for notifying the Prevea360 Health Plan Utilization Management Department within 48 hours or whenever it is medically feasible (whichever is longer) of an urgent/emergent inpatient admission. A member may require emergent/urgent inpatient admission to an acute hospital from any of the following settings:

- Home
- Doctor's office
- Emergency room
- Observation bed
- Surgical day care (SDC) unit
- Transfer from another facility *(including neonatal intensive care unit admission from another facility)*

Hospital observation admissions **do not require authorization** by Prevea360 Health Plan. They are considered an extension of the emergency care (the member received while in the emergency room).

Notifying the Health Plan of an Emergent Inpatient Admission

For payer ID 39113 we encourage providers to establish a Prevea360 Health Plan Provider Portal account and submit their emergent inpatient authorization requests through our secure Provider Portal. Member eligibility can also be confirmed in the health plan's Provider Portal through the Eligibility application. For Payer ID 41822, please use the Availity Essentials Portal.

If not working through the health plan's Provider Portal, the process for notification and submitting authorization requests for emergent inpatient admissions by phone varies depending on whether the request is made during standard business hours or outside of standard business hours. Standard business hours for the Utilization Management Department are Monday through Friday, 8:00 a.m. to 5:00 p.m., excluding federal holidays.

Providers should be prepared to provide all the following information when submitting an authorization request:

- Member name *(middle initial if available)*
- Member date of birth
- Member ID number
- Admission date *(must be the actual date the member was admitted to inpatient status)*
- Admitting/attending physician name and phone number

- Admitting diagnosis
- Type of admission: ER, direct admit, day of surgery

Hospital inpatient admissions require authorization from Prevea360 Health Plan whenever a member is admitted from an emergency room. In urgent and emergency situations, Prevea360 Health Plan must be notified of any inpatient admissions resulting from emergency room services within 48 hours or when it is medically necessary (whichever is longer).

All hospitals without Provider Portal access have two options to notify Prevea360 Health Plan of the inpatient admission:
- Fax the required admitting information to 608-252-0830
- Phone the required admitting information to 877-230-7571 option 4 ext. 4795

Urgent/emergent inpatient admissions with the exception of labor and delivery will be reviewed by Prevea360 Health Plan Utilization Management to confirm that the inpatient level of care is medically necessary. The medical necessity criteria utilized by Prevea360 Health Plan Utilization Management is nationally recognized and evidence based.

Concurrent Review

Urgent/Emergent inpatient admissions that meet medical necessity requirements will be approved for the date of admission only, pending concurrent review and ongoing medical necessity determinations for facilities that do not have a Diagnosis Related Group (DRG) contract with Prevea360 Health Plan. Hospital facilities that do not have a DRG contract with Prevea360 Health Plan are required to provide ongoing, concurrent review information for determination of the continued medical necessity of the member's stay. Concurrent review information is required to be provided to the Prevea360 Health Plan Utilization Management department from the facility's Utilization Management Department.

Facilities that have a DRG contract with Prevea360 Health Plan are not required to provide concurrent review to the Prevea360 Health Plan Utilization Management Department, however they are required to provide the date of the member's discharge from the facility. Authorization dates of service will be based on the inpatient admission and discharge dates provided by the DRG hospital facility.

ELECTIVE INPATIENT ADMISSION AUTHORIZATION

***Note*: This section is specific to non-urgent/emergent conditions ONLY.**

The hospital or servicing provider is responsible for notifying Prevea360 Health Plan **at least five to seven days prior** to the planned inpatient admission date.

Elective Admissions are defined as non-urgent/emergent inpatient services that are planned and are able to safely be scheduled at a future date and are not being admitted from one of the settings indicated in the "Urgent/Emergent Admission Notification" section above. Notification of elective inpatient admission by the servicing hospital or specialist provider is required **a minimum of five to seven days prior** to the scheduled admission date.

Elective inpatient services that were scheduled but were not prior authorized in the indicated minimum time frame are not considered an urgent/emergent service. Providers who fail to follow the indicated prior authorization requirements for Elective Admissions may be responsible for services denied as not medically necessary.

Provider Portal Authorization Submissions for Inpatient Authorizations under Payer ID 39113

Only **one** authorization will be processed for the requested inpatient elective admission. . If submitted via the Provider Portal, the determination will be viewable only to the submitting hospital or specialty provider. It is the responsibility of the submitting hospital or specialty provider to communicate the determination to the non-submitting provider. The Provider Portal and resources can be accessed from the Account Login.

Provider Portal Authorization Submissions for Inpatient Admission Authorization under payer ID 41822

If the service or procedure requires prior authorization and the member will also require an inpatient stay, you'll need to submit two authorization requests: An outpatient request for the service or procedure AND a request for the inpatient stay.

Elective Inpatient Prior Authorization Requirements

The following information is required for prior authorization of an elective admission:

- Patient name *(middle initial if available)*
- Subscriber number and date of birth
- Admitting physician/specialist's name
- Hospital's name
- Diagnosis and clinical information
- Service requested *(i.e., admission, procedure, etc.)*
- CPT code(s) appropriate to the type of admission (medical or surgical)
- Admission/Procedure date

Providers with Provider Portal access to the authorization applications must submit the required information through the Provider Portal. All providers without Provider Portal authorization access have two options to provide the required information
indicated above:

- Fax the required information to 608-252-0830
- Phone the required information to 877-230-7571 option 4 extension 4795

Concurrent Review

Elective inpatient admissions that meet medical necessity requirements will be approved for the date of admission only. Hospital facilities that do not have a DRG contract with Prevea360 Health Plan are required to provide ongoing, concurrent review information for determination of the continued medical necessity of the member's stay. Ongoing concurrent review for the continued medical necessity of the ongoing stay is required to be provided to the Prevea360 Health Plan Utilization Management department from the facility's Utilization Management Department.

Facilities that have a DRG contract with Prevea360 Health Plan are not required to provide concurrent review to the Prevea360 Health Plan Utilization Management Department, however they are required to provide the date of the member's discharge from the facility. Authorization dates of service will be based on the admission and discharge dates provided by the DRG hospital facility.

If the elective date of admission is rescheduled or cancelled, please notify the Prevea360 Health Plan Utilization Management Department at 800-356-7344, ext. 4455.

TRANSFERRING PATIENTS

If it is medically necessary that a patient receiving inpatient hospital services be transferred to another inpatient hospital facility, a plan facility should be used whenever possible.

- Prevea360 Health Plan POS or PPO members are not required to use a participating provider.
- POS members may elect to use out-of-network providers with reimbursement at the out-of-network benefit level.

Prevea360 Health Plan Hospitals are equipped to handle most critical medical, surgical and acute inpatient rehabilitation services for our members. Prevea360 Health Plan Hospitals accept patients if air ambulance is required. Contact Prevea360 Health Plan Hospitals prior to transferring to an out-of-network facility if you are unsure if a service is

available. If services are available with an in-network hospital facility, and the member is deemed medically stable by the attending physician, Prevea360 Health Plan HMO members may be transferred to an in-network facility.

When transfer to an out-of-network facility is determined to be appropriate for emergency and/or specialty care that is unavailable in-network, the admission is authorized. However, Preve360 Health Plan must be notified within 24 hours or the next business day of the transfer as well as the medically necessary reason. For all non-emergent transfers to out-of-network facilities, prior authorization is required to be obtained from Utilization Management before transfer to the out-of-network facility occurs. If a Prevea360 Health Plan HMO member is emergently admitted to an out-of-network facility, the member may be required to transfer to an in-network inpatient facility once they are medically stable. If you have any questions about transferring one of your patients, contact Customer Care Center at the phone number on the member's ID card.

OBSERVATION STAYS

Observation care is a defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

An observation stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member to determine if they may require an inpatient stay or follow-up care in another setting. An observation stay should not exceed 48 hours.

Examples considered appropriate for observation stay include, but are not limited to:

- Abdominal pain
- Asthma
- Back pain
- Bronchitis
- Chest pain
- Croup
- Concussion
- Dehydration
- Drug overdose
- False labor
- Gastroenteritis
- Migraine headache
- Pneumonia
- Renal colic/calculus
- Seizure
- Sepsis
- Syncope
- Upper limb closed fracture or dislocation

Providers are NOT required to notify or receive authorization for an observation stay in a facility. Reimbursement for observations stays is limited to a maximum of 48 hours and inpatient medical necessity criteria must be met if a member is converted from Observation to an inpatient admission. Observation stays that are converted to an inpatient admission are considered urgent emergent and require authorization as outlined in the Urgent/Emergent Inpatient Admission Notification section.

PROGRAM OBJECTIVES AND EVALUATION

The purpose of the UM Program is to ensure that health care resources are used efficiently and effectively to provide the best value to individuals and organizations purchasing health care and services. The UM objectives include, but are not limited to the following:

- Comply with State and Federal regulations, as well as National Committee for Quality Assurance (NCQA) standards
- Monitor potentially avoidable admissions and address identified areas of concern
- Focus inpatient or outpatient review activities on opportunity areas as determined by various data sources
- Monitor data to identify areas of possible over and under-utilization. Areas may include but are not limited to procedure utilization, pharmacy utilization (certain medications and classes of medications), emergency room utilization, inpatient utilization, laboratory utilization, and physician practice utilization
- Assess provider and member satisfaction with UM activities and address areas of dissatisfaction, when appropriate
- Integrate UM with Disease and Case Management as appropriate when identified during UM activities
- Monitor and analyze variations in the delivery of care in the network for which evidence-based standards of appropriate care exist, and consider opportunities to improve quality of care and reduce medical costs
- Implement or maintain policies and procedures in accordance with regulatory and accreditation requirements
- Develop or adopt UM criteria and guidelines that are consistent with generally accepted standards and are based on sound clinical evidence
- Implement and maintain a process to review emerging medical technology and new uses for existing medical technology to determine both safety and effectiveness
- Maintain a process to ensure that relevant information is collected to review medical necessity for coverage
- Employ qualified health professionals to assess the clinical information used to support UM decisions
- Maintain a process in which UM decisions are made in a timely manner and to ensure that members and providers are notified of determinations in accordance with federal and state requirements, and accreditation standards
- Provide access to staff for members and providers seeking information about the UM process and the authorization of care and prompt turnaround of decisions by qualified health reviewers
- Implement and maintain processes for objective and systematic monitoring, evaluation, and improvement of UM processes and services
- Implement and maintain processes, policies. And procedures to assist in monitoring the quality of UM decisions. These mechanisms include, but are not limited to, inter-rater reliability and manageability, case audits and the identification of potential adverse events

The UM Department annually evaluates the UM Program and submits their UM Program Evaluation to the UM Committee for review and approval. The evaluation includes a review of the UM Program using member complaints, grievance and appeal data; the results of member satisfaction surveys; practitioner complaint, grievance, and appeal data; and the results of practitioner satisfaction surveys, as appropriate. The evaluation includes both program accomplishments and limitations/barriers. Recommendations from the annual Program Evaluation are incorporated into the next year's UM Program Description and QI Work Plan as appropriate.

STATEMENT OF CONFIDENTIALITY

Prevea360 Health Plan has a Corporate Confidentiality policy that states that employees have a responsibility to ensure that all personal, member, and employee information remains confidential. Earning the trust and confidence of our members and fellow employees is a responsibility each employee shares. Every employee has an obligation to comply with Prevea360 Health Plan policies on confidentiality and with laws and regulations that apply to us and our industry. Disclosure of confidential information at work or elsewhere about members or employees violates a valued trust and that individual's legal right to confidentiality.

If an employee is found to have violated any confidentiality policy, disciplinary action, up to and including immediate termination of employment, may result.

STATEMENT OF CONFLICT OF INTEREST

Employees and consultant practitioners are prohibited from reviewing cases and request that pertain to themselves, family members, or acquaintances in which the case/request that is being reviewed and the decision reached would be influenced by personal knowledge. Employees are also prohibited from reviewing cases in which they have provided care. The case/request must be deferred to another reviewer.

Compensation plans for individuals who provide utilization review services do not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Employees are prohibited from working for other companies, while employed with Prevea360 Health Plan, where that employment may be construed as a conflict of interest.

PHARMACY

PHARMACY MANAGEMENT

Prevea360 Health Plan provides a comprehensive drug benefit for those members in a plan with prescription drug coverage. Member ID cards identify those members with a drug benefit.

A pharmacy benefit drug is a medication covered and paid for under the pharmacy benefit, oftentimes self-administered by the member. A medical benefit drug is defined as a medication that is covered and paid for under the medical benefit, oftentimes administered to the member by another healthcare professional.

Pharmacy Management includes but is not limited to:

- Formulary Tiering
- Prior Authorization and Step Therapy Requirements
- Quantity Limits
- Specialist Restrictions
- Mandatory Specialty Pharmacy
- Mandatory Generic Substitution

Prevea360 Health Plan provides pharmacy information , including medical benefit drug policies, pharmacy drug policies, formulary coverage, a listing of prior authorized drugs, and pharmacy programs information for providers on the Prevea360 Health Plan Pharmacy Services for Health Care Providers web page. Medical benefit drug prior authorization forms and policies can be accessed via the Medical Injectable List or links from prevea360.com. Pharmacy benefit drug prior authorization criteria are listed on the prior authorization forms that can be accessed through the Navitus Prescriber Portal at Prescribers.Navitus.com.

Prevea360 Health Plan notifies clinics of new pharmacy information through provider notifications including:

- The monthly https://prevea360.com/Providers/Provider-news– a newsletter specifically for Prevea360 Health Plan providers
- Policy update provider notifications – issued monthly to communicate medical benefit drug policy updates, in addition to certain medical policy updates and Health Plan initiatives, outside of the monthly newsletter.

DRUG PRIOR AUTHORIZATION PROCESS

Pharmacy Benefit Drug Prior Authorization

Prevea360 Health Plan contracts with Navitus to manage pharmacy benefit drug prior authorizations. Information about the prior authorization process for pharmacy benefit drugs is available at Navitus.com. From this website, providers can go to the Prescribers Section, choose more information for prescribers, then refer to the prior authorization area. Providers can view instructions on how to submit a prior authorization and log into the Navitus Prescriber Portal at Prescribers.Navitus.com to access the prior authorization forms. Pharmacy benefit drug prior authorization criteria are listed on the prior authorization forms. Please note that the listed fax and phone numbers on the forms for submission and Customer Care can vary.

Medical Benefit Drug Prior Authorization

Prevea360 Health Plan manages medical benefit drug prior authorizations requests with support from Magellan Rx for oncology and oncology-related drugs. Medical benefit drug prior authorization policies and forms can be accessed from the Medical Injectable List. Oncology and oncology-related medical benefit drug policy documents can be accessed from the “View Medical Oncology Drugs List” link on the Prevea360 Health Plan Document Library web page.

PEER-TO-PEER REVIEW PROCESS

Providers are encouraged to take advantage of the peer-to-peer review process before submitting a prior authorization appeal. The peer-to-peer review process offers the requesting provider an opportunity to discuss the denial determination of a pharmacy authorization request with a Prevea360 Health Plan Medical Director.

The opportunity for a peer-to-peer review is available for up to ten calendar days after the denial determination has been made. Alternatives to consider if the ten-calendar day window has elapsed include filing a formal provider appeal or directing the member to the appeals and grievance process outlined in their letter; member benefit certificate or by contacting the Prevea360 Health Plan Customer Care Center at the phone number on the member's ID card.

AUTHORIZATION APPEALS

Prevea360 Health Plan providers can appeal medical and pharmacy benefit drug denial determinations, including denials for oncology and oncology-related drugs. We strongly recommend that providers complete the peer-to-peer review process before submitting a provider authorization appeal as resolution may be reached with a verbal discussion.

Prior authorization appeals must be submitted to Prevea360 Health Plan, regardless of the entity that processed the prior authorization request. To submit an appeal for an authorization request that was submitted to Prevea360 Health Plan or Navitus, providers may submit a letter of necessity by fax to 608-252-0812 or by paper mail to: Prevea360 Health Plan, Route CP595, PO Box 9310, Minneapolis MN 55440-9310.

When submitting an appeal, review the denial reason and provide supporting documentation for the request (e.g., medical records, medication history, medical journals, etc.). If more information becomes available after the authorization request was initially denied, the authorization request may be submitted again to be reconsidered. Ultimately, the prescriber or member has the opportunity to pursue the grievance process for any drug prior authorization request that is redirected to other covered drugs or denied.

DRUG FORMULARIES

Prevea360 Health Plan has developed pharmacy benefit drug formularies specific to our benefit plans to help providers choose the appropriate drugs based on their member's needs, coverage plan, and cost of each drug. Our drug formularies are published on the Prevea360 Health Plan website at Prevea360.com/Members/Pharmacy-Benefits/Drug-formulary. If you are unsure which drug formulary applies to a member, go our online member health plan benefit information at MemberBenefits.Prevea360.com.

Formularies are available as Adobe PDFs. Users can scroll through the list or type in "Ctrl + F" to bring up the search bar to type in the name of the drug. All formularies contain the Drug Name, Special Code, Tier level, and Category the drug is listed under.

Note: The State of Wisconsin Group Health Insurance Program (for members enrolled in the Wisconsin Department of Employee Trust Funds [ETF] plan) has its own unique formulary and drug prior authorization process. Refer to the Navitus website at Navitus.com or call Navitus Customer Service at 866-333-2757 for formulary and benefit information for this member population.

PREVENTIVE DRUG LIST

Prevea360 Health Plan publishes a Preventive Drug List of covered drugs to assist providers in choosing the right drugs for their patient's needs. This resource details certain preventive medications that are available at $0 to members. For the current list, refer to the Preventive Drug List on the Prevea360 Health Plan Pharmacy Benefits web page.

SPECIALTY PHARMACY

Prevea360 Health Plan uses Lumicera Health Services for specialty pharmacy services. Lumicera is experienced in managing specialty medications and coordinating personalized support for members impacted by chronic illnesses and complex diseases. Lumicera offers free delivery, same day service, medication consultations and refill reminders. Refer to our Specialty Pharmacy Program web page for more information about Lumicera and available support for members.

Contact information for Lumicera:

- Phone: 855-847-3554
- Fax: 855-847-3558
- Address: 310 Integrity Rd. Madison, WI 53717
- Website: lumicera.com

MAIL ORDER PHARMACY

Costco is Prevea360 Health Plan's preferred mail order pharmacy. Members do not need to have a Costco membership to use this service. Refer to the mail order information on our website for more information. For additional information or for member registration, go to Prevea360.com/Members/Pharmacy-Benefits/Saving-On-Prescription-Drug-Costs.

EXCLUDED OR NONFORMULARY DRUG POLICY

Prevea360 Health Plan has an established policy for handling requests for drugs excluded from the formulary (notated as "NC" on the formulary). Physicians may request consideration for excluded drugs on an exception basis. Exception requests should be submitted using the Exception to Coverage Form, which can be found on the Navitus Prescriber Portal. Exception requests will be considered for approval only after all formulary alternatives have been tried and failed.

A contraindication to a specific formulary alternative drug constitutes a failure of the formulary alternative drug without a trial of that drug. **All drugs are excluded from the formulary until they have been reviewed and approved by the Medical Policy Committee.**

In the case of denials for exception requests, a denial letter will outline appeal options available to physicians, members, and their representatives. Pharmacy appeals for coverage under a Commercial product are reviewed by Prevea360 Health Plan's Grievance and Appeals Team**.**

OTHER PHARMACY INFORMATION

- When a member requests a brand name prescription when a generic is available, the member will be responsible for the brand name copayment along with the difference in cost between the generic and brand drug.
- Mail order prescriptions are available through Costco Mail Order Pharmacy at pharmacy.costco.com. Members do not need to have a Costco membership to use this service.
- Generic substitutions will be made by the pharmacy when Food and Drug Administration (FDA) approved generics are available.
- Insulin and diabetic supplies are a covered benefit for all members, including groups that do not have a drug benefit. The amount of coverage varies depending on the member's benefit.
- Only retail pharmacies with an active Prevea360 Health Plan Pharmacy Agreement may provide outpatient drugs to Prevea360 Health Plan members. Discharge medications or emergency room/urgent care take home drugs are considered outpatient prescriptions. These medications are not a covered benefit unless dispensed by the institution's retail pharmacy who is an in-network pharmacy provider.
- When a member has more than one insurance carrier, coordination of benefits for pharmacy claims shall occur. If Prevea360 Health Plan is the member's primary carrier, all pharmacy charges should be submitted according to the Prevea360 Health Plan filing guidelines.

In situations where Prevea360 Health Plan members treated for urgent/emergent care require medications and they do not have access to a plan pharmacy, the following guidelines apply:

- The member should be given a quantity of medication to last until they are able to access a plan pharmacy (usually a one-day supply).
- The member should be given a written prescription for the remaining medication needed.
- They should be instructed to have the prescription filled at a plan pharmacy and instructed to have the prescription filled at an in-network pharmacy.

CASE MANAGEMENT

CASE MANAGEMENT PROGRAM DESCRIPTION

Prevea360 Health Plan offers care management to optimize the overall health of our members across their health care continuum by engaging them in population informed programs and services available through the health plan, network providers, and community. Core objectives of care management programs are to help members self-manage complex or chronic conditions, promote primary care provider relationship, connect members with appropriate community resources and assist in navigation of the health care system including optimum utilization of health coverage and benefits.

Member participation in case management is voluntary, and members may opt out at any time. Please see below for how to refer patients to Case Management.

Prevea360 Health Plan's Care Management team includes nurses, social workers, engagement coordinators , and others who help members learn how to manage their health care needs. Through various outreach methods, the team provides education, support, and resources for members while promoting quality, cost-effective outcomes. An assessment of the members' health and wellness needs informs development of an individualized plan of care with member centric goals. Licensed Case Management adhere to NCQA standards for complex case management.

Case Management team members:

- Educate members on how to self-manage their diagnosis.
- Support and guide members in setting achievable goals as they work toward improving their quality of life, overall health, and well-being.
- Help members understand their individual health care plan including how to maximize benefits.
- Connect members with services and community resources necessary to self-manage their health care needs.
- Serve as an advocate to help members achieve their optimal physical and mental health.
- Help members learn how to navigate the complex health care system.
- Assist in guiding members to the best in class location for the type of transplant they need, utilizing Optum-designated transplant centers (Centers of Excellence).
- Support members with breastfeeding and pumping.

Case Management is not able to answer or resolve issues for questions specifically related to:

- Enrollment (e.g., questions about services before becoming a member)
- Billing
- Claims data
- Prior authorizations
- Denials
- Grievance and appeals
- Benefit determinations
- Provider availability and scheduling of health care appointments

CARE MANAGEMENT PROGRAMS

Advanced Illness and Advanced Care Planning

Prevea360 Health Plan's Advanced Illness program provides comprehensive care for members facing life-limiting illness, generally defined as the last twelve months of life. The model is focused on reducing the burden of illness impacting the physical, psycho-social, emotional, spiritual and environmental well-being of our members while supporting and honoring their unique traditions, culture and goals of care.

Advance care planning is the process of thinking about, communicating, and documenting future health care wishes in case of illness, accident, or sudden medical event. Prevea360 Health Plan wants to ensure that members' health care wishes are known and respected. Social workers are available to help any member over age eighteen begin or continue the process of advance care planning.

Advanced Illness nurses and advance care planning social workers help members:

- Explore personal values, beliefs, and meaning of quality of life
- Weigh options for the kind of care and treatment members would or would not want
- Consider who members should appoint to speak on their behalf
- Start the conversation with family, friends, clergy, health care and other providers
- Work to align member goals and coordination of goals with health care team and family
- Complete advance directive documents (Power of Attorney for Health Care and Living Will) to clearly state values and wishes
- Review current advance directive to ensure it continues to reflect the member's wishes

For more information, go to Prevea360 Health Plan's Care Management web page.

Behavioral Health Case Management

Behavioral health and substance use case management provides an individualized approach for members with mental health and substance use disorders to enable them to manage their health and improve their quality of life. For members with medical and behavioral needs, Prevea360 Health Plan offers an integrated program that supports members with depression, anxiety, stress, and other mood disorders.

A behavioral health case manager can help members to:

- Understand individual health care plans to self-manage health conditions.
- Coordinate care with providers, clinics, and programs to facilitate treatment for mental health or substance use conditions.
- Connect to community-based services and resources to enhance wellness.
- Understand how to use available health care services to receive the right care at the right time in the right place.
- Transition back to home after an inpatient behavioral health or substance use hospitalization.

For more information, go to Prevea360 Health Plan's Behavioral health web page.

Complex Case Management

Prevea360 Health Plan's complex case management program is a multi-disciplinary approach to the coordination of care and services provided to adult and pediatric who have a chronic or acute medical condition and who need help navigating the system to facilitate appropriate delivery of care and services.

The complex case management team helps members and caregivers:

- Navigate the complex health care system.
- Understand current acute and chronic medical conditions.
- Manage medications, including how to communicate with providers to get the best results from medications.
- Understand how to use available health care services to receive the right care at the right time in the right place.
- Identify self-care needs, including arranging referrals to therapeutic services and community-based support resources.

For more information, go to Prevea360 Health Plan's Complex case management and care coordination web page.

Pregnancy Program

Prevea360 Health Plan provides case management services to birthing parents enrolled in our Pregnancy program to promote healthy outcomes for mother and baby. The pregnancy case management team provides outreach, education, and complex case management on continuum through the pregnancy and post-partum period.

The pregnancy case management team supports birthing parents:

- Navigate the complex health care system.
- Coordinate appointments with their provider and specialists, including connecting to transportation resources as needed.
- Assess for stress and markers of depression, integrates with behavioral health care as appropriate.
- Assesses for social determinant of health needs and connects to appropriate community-based support resources.
- Develop a plan for services and supports after the birth of the baby.
- Make healthy changes – like quitting tobacco.
- Connect with local resources and find pregnancy education classes.
- Get support with breastfeeding and pumping.
- Receive support with any health concerns or chronic conditions, including behavioral health and substance use.

For more information, go to the Prevea360 Health Plan Strong Beginnings web page.

Transplant Case Management

Transplants are life changing and complex, not only affecting the member but involving their family as well. Prevea360 Health Plan's Case Management team offers support before, during, and after the procedure, providing education and coordination of services to ensure members receive the care they need. This includes guiding members to the best-in-class location for the type of transplant they need, utilizing Optum designated transplant centers through the Centers of Excellence (COE) Program.

Transplant case mangers complete both utilization management and case management functions to provide members with a seamless relationship and key points of contact with Prevea360 Health Plan.

A transplant case manager and engagement coordinator helps members:

- Understand and manage the complex disease that is leading toward transplantation.
- Coordinate care with providers, clinics, and programs through the transplant process.
- Navigate the evaluation and listing process and help them to maintain transplant readiness while awaiting transplant.
- Navigate and understand health coverage and benefits before, during, and after transplant.
- Ensure appropriate prior authorizations for transplant services are in place.
- Connect with an advance care planning social worker, if desired.

All transplant services except for cornea require prior authorization. For CAR-T services please submit prior authorization requests directly through the pharmacy department using the Medical benefit prior authorization form found here: Prevea360.com/Providers/Med-Management

For more information, go to the Prevea360 Health Plan Transplant case management web page.

Social Work Resources

Prevea360 Health Plan social workers help members to meet their goals and have a good quality of life with a focus on physical, emotional, social, and spiritual well-being.

A social worker helps members:

- Connect with housing, food and employment resources
- Find transportation resources
- Locate resources for caregiver support
- Understand how to access public benefits
- Connect socially through support groups, peer groups, and spiritual communities
- Identify resources to stay safe and report abuse, neglect, harassment and discrimination

For more information, go to the Prevea360 Health Plan Social Work web page.

CASE MANAGEMENT REFERRALS

Members may self-refer to Case Management by calling the Prevea360 Health Plan Customer Care Center at 866-905-7430 or by emailing caresupport@medica.com. .

Providers may refer a member to Case Management programs via:

- The provider referral line866-905-7430 . Provider should have the following information when calling in a member referral:
    - Provider name/office information
    - Member name
    - Member date of birth
    - Reason for referral, including pertinent diagnosis
- Email to caresupport@medica.com
- Guide patients to Health Plan Case Management websites for more info or to self-refer
    - prevea360.com/caremanagement

In addition, Prevea360 Health Plan Case Management identifies members for possible services through:

- Discharge Planners and nurse navigators
- Pharmacy data
- Claims data
- Hospital discharge data
- Health Assessments
- Internal referrals from other departments
- Prevea360 Health Plan's Utilization Management

CASE MANAGEMENT OUTREACH PROCESS

Prevea360 Health Plan's Case Management standard hours of operation are 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday excluding nationally recognized holidays.

- The goal is to outreach to members within two business days of provider or member self-referral.
- Case Management makes three contact attempts (typically two phone calls and a letter) over approximately a two-week timeframe before closing the case if a member does not respond to the outreach attempts.
- Members must engage with a Health Plan case management team member and accept referral to additional services/resources before said service can be provided (e.g., Health Plan case management cannot arrange transportation to appointments without the member's permission).

Note: Prevea360 Health Plan's case management team **does not** provide urgent or emergent services.

MEMBER GRIEVANCE AND APPEALS PROCESS

MEMBER COMPLAINT, APPEAL, AND GRIEVANCE PROCEDURE

The Complaint, Appeal, and Grievance Procedure is used to resolve member issues. We ask that our providers familiarize themselves with this process, and refer all complaints to Prevea360 Health Plan, with consent from their patients; this process may also be used by providers to file appeals or grievances on behalf of their patients.

When a complaint, appeal, or grievance has been submitted, Prevea360 Health Plan may contact a provider for more information related to the issue. We require that our practitioners respond promptly to any requests for information from Prevea360 Health Plan. This will assist us in providing a timely response and resolution to complaints, appeals or grievances filed with our office. To ensure a fair decision, Prevea360 Health Plan gives our practitioners the opportunity to discuss decisions that are based on medical necessity with a Prevea360 Health Plan Medical Director through our peer-to-peer process. The treating physician will be informed at the time of the denial by the Medical Affairs Division of how to initiate the peer-to- peer process should they want to discuss the decision. It is recommended, when available, to first exhaust the peer- to- peer process prior to pursuing the Grievance and Appeal process.

The procedure for filing a complaint, appeal, or grievance is defined below. This information is also located in the Member Certificates. Your understanding of this process will assist us in resolving member issues in a timely manner.

Complaint

Prevea360 Health Plan takes all member complaints seriously and is committed to responding to them in an appropriate and timely manner. If a member has a complaint regarding any aspect of care or decision made by you or the Health Plan, please contact the Customer Care Center at the phone number on the member's ID card. We will document and investigate the member complaint and may notify the member of the outcome of the complaint. Complaints regarding to the quality of service or quality of care of a physician, clinic, or staff are considered confidential and the outcomes are not shared with members. If the complaint is not resolved to the member's , satisfaction they can file a grievance. Because most concerns can be addressed informally, we encourage either you or the member to contact the Customer Care Center first for discussion before taking any formal action.

Grievance/Appeal

Any written expression of dissatisfaction will automatically be addressed as a grievance and/or appeal as required by product type and applicable regulations. Prevea360 Health Plan does not require a provider, or member use a specific term in order for a review to begin.

A member or their authorized representative can file a grievance/appeal in writing to the following address or fax:

Prevea360 Health Plan
Route CP595
PO Box 9310
Minneapolis MN 5540-9310
Fax: 608-252-0812

Expedited grievances/appeals, or situations that may seriously jeopardize the member's life, health, or the ability to regain maximum functionality, may also be submitted by calling the phone number on the member's ID card. In most cases, standard grievances/appeals will be researched and responded to within 30 working calendar days, while expedited grievances/appeals will be resolved and responded to within 72 hours.

Upon receipt of the grievance, Prevea360 Health Plan's Grievance and Appeal Department will acknowledge it within five business days. Our acknowledgment letter will advise the member of their right to:

- Submit additional written comments, documents or other information regarding their grievance/appeal,
- Be assisted or represented by another person of their choice,

- Appear before the Grievance and Appeal Committee if they wish to do so,
- And the date and time of the next scheduled meeting, which will not be less than seven calendar days from the date of their acknowledgment and within 30 calendar day timeframe of receiving the grievance.

If the member chooses to appear before the committee, they **must** notify us. If they are unable to appear before the committee, they do have the option of scheduling a conference call.

The member or the member's authorized representative have the right to request a copy of documents, free of charge, relevant to the outcome of the grievance by sending a written request to the address listed above.

Their grievance will be documented and investigated. All grievances will be resolved within 30 calendar days of receipt.

Independent External Review

A member may be entitled to an independent external review (IER) of a final adverse determination involving care which has been determined not to meet the Plans' requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of care, or where the requested services have been found to be experimental treatment. Determinations involving pre-existing conditions and Policy Rescissions are also eligible for IER. A member must exhaust all appeal/grievance options before requesting an independent external review.

However, if we agree with the member that the matter should proceed directly to independent review, or if they need immediate medical treatment and believe that the time period for resolving an internal grievance/appeal will cause a delay that could jeopardize their life or health, they may ask to bypass our internal grievance/appeal process. In these situations, the request will be processed on an expedited basis.

If the member or the member's authorized representative wish to file a request for an independent review, the request must be submitted in writing to the address listed above in the "Grievance/Appeal" subsection, or submitted directly to the IER if specified in the grievance/appeal decision letter, and received within four months of the decision date of the grievance.

Upon receipt of the request, a URAC accredited IER will be assigned to the case through an unbiased random selection process, unless the policy is subject to the Federal IER process in which case Maximus will be the selected IER. The assigned IER will also deliver a notice of the final external review decision in writing to the member or the member's authorized representative and Prevea360 Health Plan within 45 calendar days of their receipt of the request.

A decision made by an IER is binding for both Prevea360 Health Plan and the member with the exception of pre-existing condition exclusions and the rescission of a policy or certificate. The member is not responsible for the costs associated to the IER. The decision is binding on both the insurer (the Plan) and the insured.

Requests for benefits beyond those defined in the benefit package are not eligible for independent external review. Please contact our Customer Care Center for information regarding availability, and the process for initiating the review.

Urgent Grievance/Appeal

If the initial grievance/appeal involves the need for urgent care, we will resolve those within 72 hours of receiving the grievance/appeal according to Prevea360 Health Plan's criteria which is based upon the urgent care grievance/appeal provisions of state law. If the grievance/appeal meets criteria for an expedited grievance/appeal, meaning the situation is deemed urgent in nature or the member is receiving ongoing treatment, they are also eligible for an expedited external review concurrent with the internal expedited review of their grievance/appeal. The request may be oral or written.

Office of the Commissioner of Insurance

Problems may be resolved by taking the steps outlined on the previous pages. The member may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint. They can contact the Office of the Commissioner of Insurance by writing to:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Or they can call 800-236-8517 and request a complaint form.

QUALITY IMPROVEMENT

It is the mission of Prevea360 Health Plan to promote members' health by ensuring the right care, at the right place, at the right time, and with the right provide. The Quality Improvement Program provides the overview of how the Health Plan assesses and improves the quality of clinical care and quality of service delivered to its members.

QUALITY OF SERVICE ISSUES

Prevea360 Health Plan identifies and investigates all instances of concern for the quality of service provided to Prevea360 Health Plan members. Prevea360 Health Plan typically identifies quality of service issues through member complaints.

Prevea360 Health Plan categorizes quality of service issues as follows:

- Access To Care
- Communication/Incorrect Information
- Provider/Staff Behavior
- Privacy Breach
- Facility Physical Accessibility
- Facility Physical Appearance
- Adequacy of Space in Facility
- Adequacy of Treatment Record Keeping

All issues relating to quality of service provided to Prevea360 Health Plan members are referred to the Quality Improvement Department for investigation. Quality Improvement logs all incoming issues concerning quality of service, noting the date of receipt and the source. Quality Improvement will determine if the individual(s) involved was a Prevea360 Health Plan member at the time of service. If not, the quality of service concern is referred to the practitioner clinic and/or medical facility for investigation and resolution. This referral is documented in Quality Improvement.

Quality Improvement will investigate the issue and verify the concern for quality of service provided to members. Quality of service issues are investigated by contacting the appropriate Prevea360 Health Plan staff, as well as medical and administrative staff at practitioner clinics and medical facilities.

Quality Improvement will review the following as they pertain to the service issue:

- Prevea360 Health Plan complaint and/or grievance documentation
- Prior authorization information
- Utilization review information
- Medical records
- Any documentation of the issue at appropriate practitioner clinics and medical facilities
- Any other available information relevant to the issue

Quality Improvement will document a summary of the investigation which is reviewed by Quality Improvement Management to determine the appropriate disposition of the issue. They will conduct and complete the investigation within 30 working days of receipt.

Quality Improvement will update the log of quality of service issues, noting the actions taken by the Quality Improvement Management. They will monitor and, as appropriate, implement corrective action plans. Quality Improvement will document all activities and progress of corrective action plans.

QUALITY OF CARE ISSUES

Prevea360 Health Plan identifies and investigates all instances of concern for the quality of care provided to Prevea360 Health Plan members. Prevea360 Health Plan identifies quality of care issues through member complaints, inpatient and outpatient utilization review, case management referrals, studies, reports, and referrals from providers and practitioners. Grievance and Appeals logs all incoming issues concerning quality of care, noting the date of receipt and the source (member complaints, inpatient and outpatient review, studies, reports, and referrals from providers and practitioners). Grievance and Appeals will also send any required acknowledgement letter within 5 working days of receipt. Grievance and Appeals will then forward all quality of care issues involving a Prevea360 Health Plan member at the time of service, to the Health Services Division for investigation. If the individual involved in a quality of care complaint was not a Prevea360 Health Plan member at the time of service, the quality of care concern to the practitioner clinic and/or medical facility for investigation and resolution.

In investigating the quality of care complaint, UM will follow the Prevea360 Health Plan MPRC (Medical Peer Review Committee) Workflow process. An MPRC Case Summary will be prepared for each case investigated. The investigation may include the following information:

- Prevea360 Health Plan complaint and/or grievance documentation.
- Prior authorization information.
- Utilization review information.
- Medical records.
- Any documentation of the issue at appropriate practitioner clinics and medical facilities.
- Any other available information relevant to the issue.
- Results of an External Independent Review if there is a referral for a second level review recommended by a Prevea360 Health Plan Medical Director.

The Chair of the MPRC, the Prevea360 Health Plan Medical Director or the MPRC Committee may contact the physician under review in writing, via telephone, or electronically to request additional information or clarification. The physician is expected to respond appropriately to the request(s) for additional information. MPRC reviews, observe confidentiality, privilege of information, and immunity from liability to the extent permitted under State and Federal law.

The Chair of the MPRC or Prevea360 Health Plan Medical Director will conduct and complete their investigation of the quality of care complaint within 90 working days of receipt. This 90-day period applies only to the investigation of the Chair of the MPRC or Prevea360 Health Plan Medical Director. If the file is referred to the MPRC Committee for further investigation, that investigation may go beyond the 90-day time period. A summary of the investigation and any actions taken will be documented within MPRC. The Chair of the MPRC, a Prevea360 Health Plan Medical Director and/or Medical Peer Review Committee will determine the appropriate level of severity and disposition of the issue. Levels of Severity include:

- Level 1 – Standard of care.
- Level 2 – Marginal deviation from standard of care – MPRC review required.
- Level 3 –Significant deviation from standard of care – MPRC Committee review required.

Where the MPCR Chair or a Prevea360 Health Plan Medical Director believes a case has the potential to be leveled at a two or above, the case will be referred to the MPRC Committee for review, discussion and final determinations.

The purpose of the MPRC and its Committee is to function as an advisory board and to provide a review of medical practitioners by peers in the areas of quality of care and effective utilization of services. The outcome of the review process is to educate practitioners on issues identified as requiring improvement and to initiate any applicable remedial or

disciplinary actions. Members of the MPRC Committee are medical practitioners from various specialties. The responsibilities of MPRC include:

- Review quality of care issues identified through sentinel events monitoring, referred by peers and the QA and complaint processes of HMOs, hospitals, and other medical facilities.
- Determine appropriate remedial steps or discipline needed.
- Establish a plan for practitioner education and follow up to assure future improvements and compliance as needed.
- Monitoring data on identified quality issues.
- Provide recommendations to medical management, as needed, about individual practitioner and/or group trends or patterns relating to quality issues.

The MPRC will review the quality of care issues referred by the Chair of the MPRC or a Prevea360 Health Plan Medical Director and determine the appropriate corrective actions. Quality Improvement staff will attend the Medical Peer Review Committee meeting to support the presentation of the quality of care issues.

The MPRC will specify the activities, responsible parties, time frame, and reporting requirements for implementing corrective actions which may include a recommendation for an ad hoc recredentialing if deemed appropriate by the MPRC Committee members. MPRC will update the log of quality of care issues, noting the actions taken by the MPRC Committee. Any actions to reduce, suspend, or terminate a Prevea360 Health Plan practitioner will follow the process outlined in Prevea360 Health Plan's Credentialing Committee's policies and procedures.

The MPRC Committee will, as appropriate, implement and monitor corrective action plans. The MPRC Committee will document all activities and progress of corrective action plans.

ACCESSIBILITY OF SERVICES

Prevea360 Health Plan has set standards for member access to services provided by primary care practitioner, behavioral health, and specialty care practitioner clinic locations.

Access to Primary Care

Prevea360 Health Plan defines the following practitioners as primary care practitioners: Internal Medicine, Family Medicine, General Practice, and Pediatric Medicine. The access standards for primary care practitioner clinic locations are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Regular and routine care appointments	Within 30 days
Urgent care appointments	Within 48 hours
After-hours care	Primary care clinic locations must have information available and accessible to members regarding after-hours care and 24-hour emergency room access.

Access to Specialty Care

Prevea360 Health Plan assesses specialty care accessibility for practitioners identified as high-volume or high impact. The access standards for specialty care clinic locations are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Regular and routine care appointments	Within 30 days
Urgent care appointments	Within 48 hours

Access to Behavioral Health Care

Prevea360 Health Plan assesses behavioral health care accessibility with any of the following providers: Psychiatrists, Psychologists, Other Therapists (e.g., LPC, LCSW, LMFT, MS), and Alcohol and Other Drug Abuse (AODA) Counselors. The access standards for behavioral health clinic locations are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Non-life threatening emergency	Within 6 hours
Urgent care appointments	Within 48 hours
Initial visit for routine care	Within 10 business days
Follow-up routine care with Prescribers (e.g., psychiatrists)	Within 30 days
Follow-up routine care with non-Prescribers (e.g., psychologists)	Within 20 days

Appointment Accessibility Assessment Survey

Prevea360 Health Plan conducts an annual Appointment Accessibility Assessment of all primary care, behavioral health, and specialty care practitioner clinic locations within the Prevea360 Health Plan network. This is accomplished through a self-assessment appointment access survey sent annually to practitioner clinic locations for completion. The Health Plan compiles and evaluates the results from the survey and presents that information annually to the Quality Improvement Committee (QIC).

CLINICAL GUIDELINES

Prevea360 Health Plan, in cooperation with our providers, is dedicated to continually improving the quality of care for our members. Prevea360 Health Plan has adopted the following guidelines to help providers make health care decisions for their patients at Prevea360.com/Providers/Clinical-Guidelines. They are not intended to replace clinical judgment.

HEDIS REPORTING REQUIREMENTS

HEDIS (Healthcare Effectiveness Data and Information Set) is a standardized set of performance measures that assess plans' performance on a number of elements, including such things as financial stability, access, and quality of care.

Prevea360 Health Plan annually collects data and reports on performance measures from HEDIS relevant to the commercial, Medicaid, and Medicare populations. Prevea360 Health Plan uses HEDIS information to assess the quality of care delivered by plan practitioners and providers and identify improvement projects and studies.

All plan practitioners and providers are expected to cooperate with Prevea360 Health Plan in the accurate and timely reporting, collection of data, and review of medical records. Prevea360 Health Plan will collect data according to HEDIS specifications and notify practitioners and providers of any additional information requirements and will also identify and communicate the names of patients for medical record review. All practitioners and providers are expected to provide Prevea360 Health Plan with timely access to medical records, as requested, and allow Prevea360 Health Plan to print and/or make photocopies, as necessary.

RISK ADJUSTMENT

The Risk Adjustment Program was established by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS) as a requirement of Medicare Advantage Organizations and the Affordable Care Act (ACA). The program requires health plans to submit claims and detailed documentation pertaining to each Medicare Advantage and Commercial ACA member in a specific format for each benefit year. The specific

diagnoses of each plan member must be documented in accordance with ICD-10 standards and supported by valid documentation within the patient's medical record **each year**. All current or active diagnoses should be documented by an advanced practitioner or MD/DO that exist at the time of the face-to-face encounter/visit, and require or affect patient care.

Prevea360 Health Plan has created an internal audit process to comply with CMS and HHS requirements of capturing and submitting complete and accurate severity and disease status of their members. We contract with a vendor to identify members for patient medical record review throughout the year. The vendor's medical record review is to support the internal process and ensure that our records properly reflect the clinical condition(s) of our Medicare Advantage and Commercial ACA members.

Annually, Prevea360 Health Plan must comply with the HHS Risk Adjustment Data Validation (RADV) audit of our Commercial ACA members by using an independent auditor. The independent auditor must retrieve and review the medical records for the members identified by HHS for the audit. All in-network providers are expected to cooperate with Prevea360 Health Plan in the accurate and timely collection of data and review of medical records. All providers are expected to provide Prevea360 Health Plan, and those working on behalf of Prevea360 Health Plan with a Business Associate Agreement (BAA), with timely access to medical records, as requested, and allow these entities to print and/or make photocopies, as necessary.

Applicable to providers participating in our Medicaid program only, Prevea360 Health Plan has also created an internal audit process to comply with CMS requirements for their Program Integrity initiative, administered by Forward Health. Prevea360 Health Plan is required to report any information uncovered that may indicate possible fraud, waste, and abuse seen in billing practices to Forward Health, which may result in follow up and additional investigation.

MEMBER RIGHTS AND RESPONSIBILITIES

Prevea360 Health Plan members deserve the best service and health care possible. Prevea360 Health Plan is committed to maintaining a mutually respectful relationship with its members. Rights and responsibilities foster cooperation among members, practitioners and Prevea360 Health Plan. Member Rights and Responsibilities are outlined in this section. Prevea360 Health Plan also publishes member rights and responsibilities.

Prevea360 Health Plan members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive a listing of Prevea360 Health Plan's participating practitioners in order to choose a primary care provider.
- Submit a question, complaint, or grievance to Prevea360 Health Plan about the organization or the services it provides without fear of discrimination or repercussion.
- Receive information on procedures and policies regarding their health care benefits.
- Timely responses to requests regarding their health care plan.
- Request information regarding Advance Directives.
- Participate with practitioners in making decisions about their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Receive information about the organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policies.

Prevea360 Health Plan members have the responsibility to:

- Read and understand the materials provided by Prevea360 Health Plan concerning their health care benefits. We encourage members to contact Prevea360 Health Plan if they have any questions.
- Present their member ID card to identify themselves as Prevea360 Health Plan members before receiving health care services.
- Notify Prevea360 Health Plan of any enrollment status changes such as family size or address.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed on with their practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Fulfill financial obligations as it relates to any copays, deductibles and/or premiums as outlined in your policy.

MEMBER PRIVACY POLICY

Protecting the Privacy of Your Personal Health Information

Prevea360 Health Plan is required by law to maintain the privacy of your personal health and financial information (collectively referred to as "nonpublic personal information") and provide you with written notification of our legal duties and privacy practices concerning that information. This Notice describes how we protect the confidentiality of our members' (and former members') nonpublic personal information. It includes brief explanations on how we obtain, use, and protect your nonpublic personal information.

Types of Nonpublic Personal Information Prevea360 Collects About You

We collect a variety of nonpublic personal information needed to administer health insurance coverage and benefits. We collect nonpublic personal information about you from some of the following sources:

- Information we receive directly or indirectly from you or your employer or benefits plan sponsor through applications, surveys or other forms. The information may be received in writing, in person, by telephone or electronically. Examples include name, address, Social Security number, date of birth, marital status and medical history.
- Information about your transactions with us, our affiliates, our providers, our agents and others. This includes information from health care claims, medical history, eligibility information, payment information, service request, and appeal and grievance information.
- Information you authorize us to collect from others.

Choices about Your Health Information

We will not use or disclose your health information without your written authorization, except as described in this Notice. You generally have the right and choice to tell us to:

- Share information with your family, close friends or others involved in payment for your care.
- Share information in a disaster relief situation.

In the following cases we never share your information unless you give us written permission:

- Most uses and disclosures of psychotherapy notes.
- Marketing purposes.
- Sale of your information.

If you do give us written authorization to use or disclose your health information for a particular purpose, you may change your mind at any time. You must let us know in writing if you change your mind.

How Prevea360 May Use or Disclose Your Health Information

We will not disclose your nonpublic personal information unless we are allowed or required by law to do so. The following categories describe the ways that Prevea360 may use and disclose your nonpublic personal information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure we might make will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Note: Some of the uses and disclosures described in this notice may be limited in certain cases by applicable State laws that are more stringent than Federal laws, including disclosures related to mental health and substance abuse, developmental disability, alcohol and other drug abuse (AODA), and HIV testing.

We are allowed to use and disclose information that falls within one of the following categories:

- **Payment**: we may use and disclose your health information to make and collect payment for treatment and services you receive, such as: determining your eligibility for plan benefits, obtaining premiums, determining your health plan's responsibility for benefits, and collecting payment for your health services.

- **Health Care Operations**: we may use and disclose your health information to support our business activities and improve our coverage and services. However, we are not allowed to use genetic information to decide whether we will give you coverage or the price of that coverage. Health care operations include such activities as:
    - Underwriting
    - Premium rating
    - Claims
    - Other functions related to plan coverage
    - Quality assessment and improvement activities.
    - Activities designed to improve health and reduce health care cost.
    - Case management and care coordination.

  Notice: We are part of an Organized Health Care Arrangement (OHCA) with SSM Health and P Health System. As part of the OHCA, we may from time to time share your information with other members of the OHCA in order to perform joint health care operations. These uses and disclosures allow the OHCA to run efficiently. For example, we may share your information in order to: improve population health management; conduct quality assessment and improvement activities; conduct or arrange for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general OHCA administrative activities.
- **Treatment**: we may disclose your health information to a physician or other health care provider that is treating you. We may contact you with information on treatment alternatives and other related functions that may be of interest to you.
- **Distributing Health-related Benefits and Services**: we may use and disclose your health information to provide information on health-related benefits and services that may be of interest to you.
- **Disclosure to Plan Sponsors**: if applicable, we may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan. If you have a group health plan, your employer is the plan sponsor.
- **Public Safety**: we can share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and preventing or reducing a serious and imminent threat to the health or safety of a particular person or the public.
- **Research**: under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- **Required by Law**: we will share information about you if laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- **Workers' Compensation, Law Enforcement, and Other Government Requests**: we can use and share health information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.
- **Legal Actions**: we may disclose your health information in the course of any administrative or judicial proceeding.

How Prevea360 Protects This Information

We limit the collection of nonpublic personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to safeguard your nonpublic personal information. We limit the internal use of oral, written, and electronic nonpublic personal information about you and ensure that only authorized staff and business associates with the need to know have access to it. We maintain safeguards for your nonpublic personal information and review them regularly to protect your privacy.

Your Health Information Rights

- **Right to Request Restrictions**: you have the right to request restrictions on certain uses and disclosures of your health information.

- **Right to Request Confidential Communications**: you have the right to receive your health information through a reasonable alternative means or at an alternative location.
- **Right to See and Copy**: you have the right to see and copy certain health information about you.
- **Right to Correct Records**: you have a right to request that Prevea360 correct certain health information held by Prevea360 if you think it is incorrect or incomplete.
- **Right to Accounting of Disclosures**: you have the right to receive a list or "accounting of disclosures" of your health
- **Information made by us in the past six years**: the list will not include disclosures made for purposes of treatment, payment, health care operations, or certain other disclosures (such as those you asked us to make).
- **Right to Copy of Notice**: you have a right to receive a paper copy of this Notice at any time.
- **Right to be notified of a Breach**: you will be notified in the event of a breach of your unsecured protected health information.

Changes to this Notice of Privacy Practices

Prevea360 may change this Notice from time to time and make the new provisions effective for all nonpublic personal information we maintain, including information we created or received before the change. Prevea360 will always comply with the current version of this Notice.

Complaints

Please submit complaints about this Notice or how we handle your health information, in writing, to our Privacy Officer. Prevea360 will not hold any complaint you submit against you in any way. In addition, if you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

If you have questions, complaints or want to exercise any of your health information rights, call the Customer Care Center at the phone number on the member's ID card.

Historical Revision Log

The grid below lists recent past revisions to the manual for historical reference.

Description of Change	Manual Revision Date
Updated: Phone number for the Claims Manager.	January 2023
Updated: Counties listed in the Prevea360 Health Plan service area, including counties added to the network to serve enrollees in the State of Wisconsin Employee Trust Fund (ETF) product.	January 2023
Updated: Provider information components to ensure current and accurate provider information is in the Provider Directory.	January 2023
Added: Prevea360 Western WI Health Plan for State of WI Employees information.	January 2023
Added: Sample member ID card image for Prevea360 Western WI Health Plan for State of WI Employees.	January 2023
Updated: Features the online Prevea360 Health Plan Member Resources Reference Guide for Providers as a one-stop resource for information regarding member programs and services.	January 2023
Updated: Clarified 277 Claim Acknowledgement response and Confirmation Reports Portal information; available tools to help prevent billing gaps and payment delays.	January 2023
Added: Section regarding cancelled prior authorization requests.	January 2023
Updated: Removed physician signature requirement from pre-service medically urgent for outpatient in the Authorization Priority Definitions table.	January 2023
Added: Concert Genetics as the Health Plan's contracted vendor for genetic testing.	January 2023
Updated: Locations to access for medical benefit drug policies and pharmacy benefit drug policies.	January 2023
Updated: Case management information throughout to reflect current program offerings.	January 2023
Added: Telephone number for new Language Assistance Line.	June 2022
Added: Health equity section, including information about our new web page.	June 2022
Updated: Commercial and ACA member ID card sample to show deductible amount, deductible/coinsurance maximum amount, and out-of-pocket maximum amount to represent a card for a member who has a different deductible/coinsurance maximum amount from their out-of-pocket maximum amount.	June 2022

Updated: Health Plan's provider communication offerings to include monthly policy update provider notifications and Provider Onboarding Guide.	June 2022
Added: Free language assistance interpreter services for in-network providers interacting with Prevea360 Health Plan members.	June 2022
Added: Information regarding Prevea360 Health Plan's Behavioral Health Provider Annual Training created specifically for in-network Behavioral Health providers.	June 2022
Added: Reminder to also update National Plan and Provider Enumeration System (NPPES) when there are changes to provider information.	April 2022
Added: Organizational provider types required to be credentialed under Centers for Medicare and Medicaid Services (CMS) standards.	April 2022
Added: Steps to correct a claim and more information regarding adjustments.	April 2022
Updated: The Health Plan manages medical benefit drug prior authorizations(formerly managed by Navitus Health Solutions). Forms will continue to be available through the Navitus Prescriber Portal. Navitus will continue to manage pharmacy benefit drug authorizations.	April 2022
Updated: Health Plan's mail order pharmacy is Costco.	April 2022
Updated: Provider types for primary care and behavioral health.	April 2022
Updated: Accessibility of Services for member access to primary care practitioner, behavioral health, and specialty care practitioner clinic locations.	October 2021
Updated: Access paths and direct links to Prevea360 web pages and resources that may have changed due to the recently enhanced website.	October 2021
Added: Chippewa and Eau Claire counties to Prevea360 Health Plan Medicare Advantage Service Area for 2022.	October 2021
Updated: Product descriptions for Prevea360 Preferred Provider Organization (PPO) with new wrap network First Health information.	July 2021
Updated: Member ID Card images for Preferred Provider Organization (PPO) products and Commercial and Individual plans.	July 2021
Updated: Importance of using real-time eligibility resources (270/271 & Provider Portal) when verifying member eligibility.	July 2021
Added: New Provider Communications page as a provider communication resource.	July 2021
Added: Advance Care Planning video information, Emmi, Foodsmart, and Wellness Events.	July 2021

Added: Failure to comply with credentialing and recredentialing requirements and timelines.	July 2021
Added: Opportunity to correct errors on provider applications when necessary.	July 2021
Added: Automated authorization available in the Prevea360 Health Plan Provider Portal for some services.	July 2021
Added: Tips for Submitting Prior Authorization Requests.	July 2021
Updated: Musculoskeletal (MSK) Care Management Program summary to reflect that prior authorization is no longer required for outpatient hip and knee.	July 2021
Added: Navigation tips.	March 2021
Added: Information and link to the online Provider Network Application.	March 2021
Added: Health Plan Communications for Providers.	March 2021
Updated: Provider Portal features to reflect the new applications and new Opt in for health plan communications available in the new Prevea360 Health Plan Provider Portal introduced in March 2020.	March 2021
Changed: Retitled "Authorization Process" section to "Utilization Management." This section has also been reorganized.	March 2021
Added: Medical Management section replacing certain policy specific sections. It provides guidance on where to find specific medical policies and other medical management resources to ensure access to the most current information.	March 2021
Updated: Prevea360 Health Plan no longer requires autism treatment providers to have an autism diagnosis indicator on a member's file.	March 2021
Changed: Intensive Outpatient Services now require an authorization even when provided in an office or clinic setting.	March 2021
Added: Lumicera Specialty Pharmacy is Prevea360 Health Plan's preferred specialty pharmacy.	March 2021
Added: Prevea Care After Hours phone number	January 2020
Added: Necessary approvals for providers to begin providing services to Prevea360 Health Plan members	January 2020
Added: Reporting a replacement practitioner	January 2020
Added: Member-related information and resources for providers	January 2020
Added: Prevea Partnered Health and Prevea360 Health Plan Affordable Care Act (ACA) Individual Plans	January 2020
Added: Example of Prevea Partnered Health Identification Card	January 2020
Added: Delegation agreement information and credentialing and licensure lapse information	January 2020
Added: Water transportation to Ambulance Services	January 2020

Added: Autism Services section	January 2020
Updated: Physical and occupational therapy authorizations for Initial eight visits and end dated authorizations on December 31st every year	January 2020
Updated: Pharmacy benefit drug policies are no longer posted on prevea360.com. Prior Authorization (PA) criteria is listed on the PA form, accessible through the Navitus Prescriber Portal, at prescribers.navitus.com	January 2020