Apricus Physical Medicine Provider Manual

Workers' Compensation

Spring 2025

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Corporate Overview

Apricus Specialty Solutions offers one-stop-shop experience for all equipment and services, with clinical oversight and a national specialty provider network to provide a program that delivers outstanding results and injured employee satisfaction. With roots in both clinical and network services, we leverage more than 40 years of industry experience, knowledge, and data analytics. We focus on total outcomes because we believe supporting providers supports injured individuals.

- ✓ Clinical Reviews & Evaluations
- ✓ 400k+ Specialty Service Providers
- ✓ Nationwide Coverage

Our integrated suite of solutions enhances network development, clinical integration, and operational efficiencies for employers, insurance carriers, and third-party administrators.

Key Events in Apricus' History

As the specialty network brand of Enlyte, Apricus provides injured employees and payers access to a complete physical medicine solution which utilizes a multidisciplinary specialty network. It's integrated with bill review and data analytics programs to establish a full view of medical spend trends and additional vertical integration capabilities across utilization review (UR) and case management.

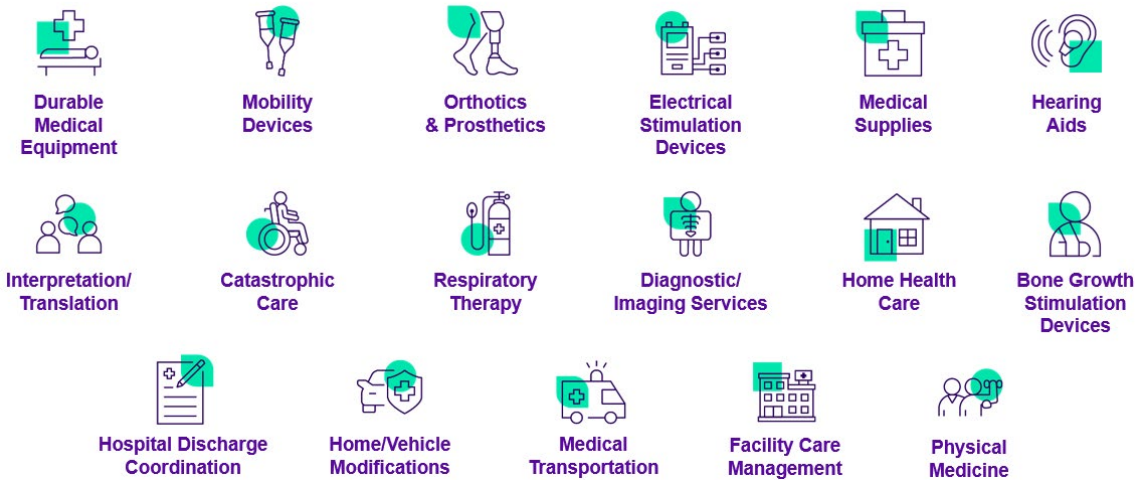
In September 2023, Enlyte acquired Therapy Direct. The acquisition is a natural extension of Enlyte's position as a market leader in provider network access, care management and workers' compensation services. For Tennessee-based Therapy Direct, the deal provided greater investment of its national network of physical medicine providers including physical therapy, chiropractic and acupuncture services in 48 states.

Apricus Physical Medicine is powered by a vast network of licensed rehabilitation therapists from approximately 10,000 physical therapy facilities nationwide.

Apricus Specialty Solutions

The Apricus Specialty Network® is the largest national network in the workers' compensation industry. For providers participating in the Apricus Specialty Network, we direct care to your practice for insurance carriers, third-party administrators, and employers in your area.

Products and Services



For more information about our products and services, please visit enlyte.com

Physical Medicine

Apricus Physical Medicine specialties include:

- Acupuncture
- Aquatic Therapy
- Certified Hand Therapy
- Chiropractic
- Functional Capacity Evaluation (FCE)/Impairment Rating
- Occupational Therapy
- Physical Therapy
- Work Conditioning
- Work Hardening
- Lymphedema
- Massage Therapy
- Speech Therapy
- Vestibular Therapy

Our Apricus Physical Medicine Provider Manual outlines all Apricus provider guidelines. Please ensure you are up to date on state specific requirements.

Durable Medical Equipment (DME)

Standard DME

- Ambulatory aids – walkers, crutches, canes
- Hearing aids & supplies
- Bath & hygienic equipment
- CPM, cold therapy, wound vac
- Manual & power wheelchairs
- Oxygen & respiratory therapy
- Bathroom safety items
- Hot & cold therapy
- Cushions, pillows & rolls
- Custom equipment

Orthotics and Prosthetics

- Custom & off the shelf

Electrotherapy Units and Supplies

- TENS units
- Muscle stimulators
- Galvanic & Interferential stimulators
- Bone growth stimulators

Specialty Rehab Equipment

- Custom wheelchairs & scooters
- Lift chairs & lifts
- Specialty beds, mattresses & bed care products
- Physical therapy equipment
- Compression therapy

Modification Services

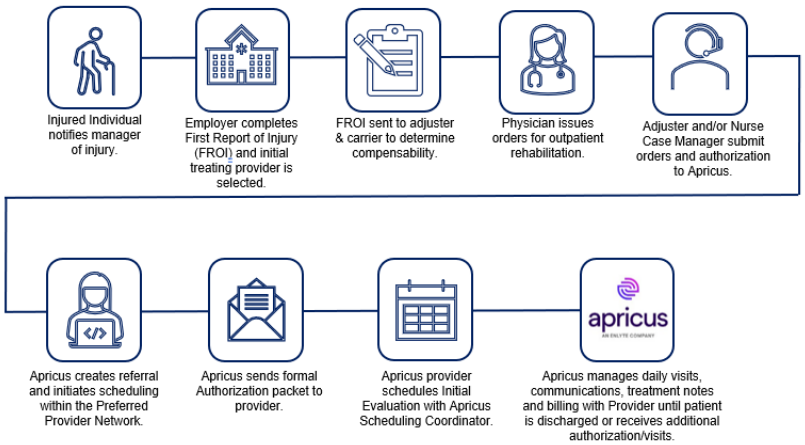
- Home, vehicle & workplace

Treating Injured Individuals

Workers' Compensation vs Group Health

- Unlike group health, where a claim refers to a single bill, every aspect of an injured worker's care falls under a single claim.
    - A claim in workers' compensation is an episode of injury or illness.
- Patients bear no responsibility for payment in workers' compensation.
    - The payer and/or employer pay the provider.
    - There are no co-pays, coinsurance, deductibles or caps.
- Medical care and indemnity costs are covered while injured individuals are unable to work.
- The claim is focused on medical treatment and return-to-work (RTW) guidelines as specified by the jurisdiction state.
- Insurer or payer "owns" the claim until it is settled, closed or maximum medical improvement (MMI) is reached.
- The medical provider receives an Explanation of Review (EOR) not an Explanation of Benefits (EOB).

Cycle of an Injured Worker



Provider & Company Commitments

1. Provider will use its best efforts to schedule a Claimant within two business days from the date of referral from Company by defining Company referrals as priority access within scheduling protocols.
2. The Provider agrees to meet for strategic management operating reviews as reasonably requested to discuss topics including but not limited to; quality outcomes, scheduling / appointment lag, clinic developments, and WC sales support.
3. Physical Medicine prescriptions(s) will be faxed to the Provider prior to the initial evaluation. After a Claimant's initial evaluation, the Provider will make its best effort to fax to Company a copy of the initial evaluation summary on the same day as, but in any case, within 48 hours of completion of the initial summary at the following number, 678-298-6271. The summary report shall include all findings, proposed course of treatment, expected results, and anticipated disability time frame. Only one initial evaluation will be allowed per Claimant. Surgical intervention will allow for a second initial evaluation for Claimant, only with prior approval. No more than one re-evaluation will be reimbursed within a 4-week period.
4. The Provider shall submit the name of treating therapist on box number 31 of HCFA 1500 claim form.
5. All therapy treatment plans must be authorized by the Company for scheduled treatment to begin. The first follow up treatment visit after the initial evaluation should be scheduled within 48 hours of the evaluation visit. All approved visits thereafter should be scheduled in a timely fashion to promote prompt patient recovery and return to work efforts.
6. A detailed progress summary is required bi-weekly. The Provider may use its own forms for notes, if notes provide adequate information. The Company may request additional information, in its discretion.
7. Re- Authorizations requests must be faxed to Company at the fax number provided above and must include the physician prescription for continued services or physician-signed plan of care and a progress summary dated within 2 weeks of the request. On the fax cover sheet in the "attention to" line, insert "authorization request." If requested visits will exceed visit guidelines as provided at time of the referral, the Company may require a peer clinical review to be performed by a Company-credentialed physical medicine clinician, which may include a call to the treating provider.
8. Provider must contact Company by the end of business day, by phone, fax or email, if a Claimant does not come to a scheduled appointment or reschedules or changes the appointment.
9. A discharge summary shall be completed within 1 week of discharge from services and faxed to Apricus at the number above.
10. The Provider must bill the Company at full non-discounted customary charges and not the contracted rates. The HCFA 1500 form or UB-04 form are the accepted forms for billing. A hard copy of the medical notes shall be attached with the related HCFA billing form. Treatment notes require Claimant time in and time out. In the event that notes are not included with the submitted claim, Company will contact Provider to obtain notes. If notes are not received within one week of contact, the Company may, in its sole discretion, deny the claim in question until notes are received. The Provider shall never bill, or balance bill the Payor or Claimant directly, for any reason. All billing questions should be directed to Company.

State-Specific Requirements

Some states have specific rules and regulations outlining how bills should be processed. It is important to familiarize yourself with the rules & regulations.

Texas Providers: In accordance with Texas Administrative Code 28 §10.42(d), Apricus Specialty Solutions hereby notifies our Texas providers that we conduct economic profiling and utilization management studies that may compare your practice patterns to those of other providers. These activities help us maintain network quality and may influence network management decisions, including provider tier placement and referral patterns

Initial Credentialing and Recredentialing

Apricus Specialty Network is partnered with Verisys whereby all provider credentialing activities will be completed by Verisys. Our implementation team will initiate the process with our providers upon employment of new contracts.

IMPORTANT NOTE: Apricus Specialty Network uses the Council for Affordable Quality Healthcare (CAQH) as its single- source of all required provider credentialing information. Under the CAQH program, providers use a standard application and a common database to submit one application to one source to meet the needs of all the health plans and hospitals participating in the CAQH effort. To learn more about CAQH visit them at CAQH - Streamlining the Business of Healthcare.

Please ensure to give Apricus Specialty Network global authorization with CAQH. Authorizing Apricus Specialty Network, access to your application is easy. The CAQH application includes the Healthcare Organization Authorization page.

Preparation & Processing of Bills

All bills must be submitted to the Apricus using HIPAA compliant coding and claim preparation guidelines.

1. The Initial Evaluation is billed with the first treatment visit only and is payable in addition to the Daily Rate.
2. The Daily Rate is a flat rate for all modalities billed per visit, per therapy type.
3. The Provider will submit separate claims when multiple disciplines (e.g., physical therapy and occupational therapy) are provided on the same day using applicable modifiers. The visit rate is applicable for each therapy type.
4. Current Year DMERC is defined as the percentage of Current Year Durable Medical Equipment Regional Carrier Fee Schedule for the applicable state.
5. All supplies and DME must have prior approval.
6. Payment for services indicated on the claim form will be considered full payment of services and will discharge the Company, its owners, agents, and employees from any further financial obligations. Payment shall be made to the name/address indicated in FL33 of a CMS-1500 or FL1 of a UB-04 claim form and must reconcile to the Service Provider authorized to treat the patient.
7. The Provider will submit claims using permitted standard code sets (e.g., CPT-4, ICD-10, or its successor standard, HCPCS) as required by the applicable Federal or State regulatory authority.

Providers can submit paper bills to the Apricus; however, we support electronic billing (e-billing).

Apricus Contacts At-a-Glance

Provider Resources **Apricus Provider Resources**

Visit the website for essential tools related to:

- Vendor Relations
- Claim Inquiries
- Issue Resolution
- Provider Benefits
- Specialty Solutions

Apricus Vendor Relations:

Email us at Vendor_Relations@apricusinc.com to:

- join our program,
- send facility updates,
- ask questions regarding your contract and rates.

Clinical Oversight & Support:

Clinical@apricusinc.com

Participating Provider Claim Inquiries

Are you looking for a payment? Do you need a claim status update? Please call or email for support:

CS_Support@apricusinc.com 833.930.0213

Can we help you resolve a complaint or grievance?

Complaints_grievances@apricusinc.com 800.262.6122

Apricus Specialty Solutions
Attention Specialty Complaints & Grievances
5210 E. Williams Circle, Suite 220
Tucson, AZ 85711