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**HealthSpan** is a comprehensive preferred provider network (PPO) of hospitals, physicians and ancillary services with over 120,000 covered lives. **HealthSpan** provides convenient access to care with greater than 100 hospitals, more than 16,000 physicians and over 1000 allied services located throughout Greater Cincinnati, Dayton/Springfield/Lima Ohio, Northern Ohio (Toledo), Northern Kentucky, Indianapolis, and Southeastern Indiana.

The network was developed in 1991 as a joint venture, by The Christ Hospital, Mercy Health Partners and the Franciscan Health System of the Ohio Valley in Cincinnati, Ohio. In September 1998, **HealthSpan** was purchased by Mercy Health Partners of Southwest Ohio, located in Cincinnati, Ohio. Mercy Health Partners of Southwest Ohio, is part of Catholic Health Partners. Effective January 1, 2009 HealthSpan is solely owned by Catholic Health Partners.

**Provider Administrative Manual**

This *Provider Administrative Manual* is your reference guide and provides a comprehensive overview of the **HealthSpan** procedures you are required to follow to ensure the efficient delivery of health care to your patients and timely payment to you for health care services rendered. This manual only applies to the services you provide to **HealthSpan** members.

This manual is a supplement to the **HealthSpan** Participation Agreement you have signed. Please note that sections of this manual may be changed from time to time.

**Networks**

The member identification (ID) card identifies which network a member can access. Please see the payer-specific ID card section of this manual to determine whether the member you are seeing is a **HealthSpan** member.

**HealthSpan** has two PPO networks: **HealthSpan** and **HealthSpan Preferred**. The physician and ancillary network is the same for both **HealthSpan** and **HealthSpan Preferred** and a common fee schedule is in place for both network products.

**HealthSpan** has a high value network for Medicare Advantage HMO Product in partnership with Mount Carment Health Plan, Inc., Medigold whose corporate office is based in Columbus, Ohio and a Partnership with SummaCare Medicare Advantage PPO Product whose corporate office is in Akron, Ohio.
Key Contacts and Important Phone Numbers

<table>
<thead>
<tr>
<th>CONTACT/AREA</th>
<th>WHEN TO USE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Management</td>
<td>Fax, submission of requested medical documentation/records, fax prior authorization requests</td>
<td>FAX (513) 551-1439 Or (513) 551-1438</td>
</tr>
<tr>
<td>Medical Management Department</td>
<td>Authorization requests, medical information or case review updates, verification of authorization</td>
<td>(513) 551-1420 or 1-800-972-7726</td>
</tr>
<tr>
<td>Network Services Department</td>
<td>Network issues, provider credentialing, claim pricing</td>
<td>(513) 551-1440 1-888-914-7726 FAX (513) 551-1449</td>
</tr>
</tbody>
</table>

CLAIM QUESTIONS - contact the member’s TPA. Refer to the back of the member’s identification card.

MEMBER ELIGIBILITY and/or BENEFITS - contact the member’s TPA. Refer to the back of the member’s identification card.

AUTHORIZATION VERIFICATION – If HealthSpan is identified on the ID card as the utilization management contact, call HealthSpan Medical Management at (513) 551-1420 or 1-800-972-7726 after verification of benefits through the Third Party Administrator.

Reimbursement Disputes – contact the member’s TPA. Refer to the back of the member’s identification card.
Providers have specific rights during the credentialing and recredentialing process. The following list describes the provider rights.

► The provider has the right to review information submitted to support their credentialing application. This includes any information used to evaluate the application with the exception of references, recommendations or other peer-review protected information. Practitioner rights are posted on the HealthSpan network website and also in the provider manual.

► The provider has the right to correct erroneous information. If practitioner/provider indicates there is a need to provide corrected information, such corrections must be received within two weeks of advising HealthSpan there is an error. Corrected information must be submitted in writing. It can be submitted either to the Network Services Representative handling the credentialing application, the Network Services Manager or the Network Services Director. Network Services in turn, will supply a written notification that the corrected information has been received and noted on the application.

► The provider has the right to receive status of their credentialing application on request. Network Services will respond with a status update within two business days of the request. The response may be via voicemail, email, fax or actual phone conversation. Network Services will only advise as to receipt of the application and where in the process the application is. Steps in the process are; application receipt, application review, requests for clarification or request for missing documentation, committee review, denial or approval.

► The provider has the right to receive notice/copy of their rights. HealthSpan notifies practitioners of their rights by posting them to the HealthSpan website and in the provider manual. Any provider can also request a copy of provider rights by phone, email, fax or written correspondence.
Physicians

General Responsibilities

The following list describes your general responsibilities as a participating provider:

► Have a current, unrestricted license to practice medicine in the state in which services are regularly performed

► Provide required credentialing documentation to the HealthSpan Medical Advisory Committee

► Work cooperatively with others and uphold the standard of ethics for the health care profession

► Be cost conscious in the provision of health care, without compromising quality patient care

► Possess a current, unrestricted Drug Enforcement Agency (DEA) certificate, if applicable

► Have professional liability coverage that meets HealthSpan’s standards for participation

► Abide by the rules and regulations and all other lawful standards and policies of HealthSpan

► Prepare and complete, in a timely fashion, medical and other related records for all members receiving medical care

► Notify HealthSpan immediately in writing of any reduction or cancellation of licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance, or any other change which would affect participation with HealthSpan

► Accept HealthSpan members as patients and provide / coordinate all needed services to members as your patient load and appointment calendar permit and without regard to race, religion, gender, color, or national origin.

► Refer members only to other providers who participate with HealthSpan

► For Medicare Advantage(MA) programs, Provider shall refer MA Members to MediGold Providers

► Hospitalize members only in participating facilities for medically necessary conditions

► Notify HealthSpan if practice is closed to new patients
PROVIDER RESPONSIBILITIES

► Create and maintain member records, and ensure these records are accessible for review in order to disclose the extent of the services provided to members

► Fully cooperate with any utilization review, quality improvement, peer review, and/or other programs developed by HealthSpan to promote quality standards of medical care including but not limited to:
  ► Providing adequate access, availability and quality of service
  ► Walk-ins will be seen if they present a true emergency otherwise they will be offered an appointment as defined below

► Appointment availability
  ► Urgent Care - Urgent medical problems are those which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or do substantially restrict a member’s normal activity (infectious illness, flu, respiratory ailments, etc.). Urgent care problems will be seen within 24 hours.
  ► Routine non-urgent care - Non-urgent problems which do not substantially restrict normal activity but could develop if left untreated (e.g., chronic disease). Routine care will be provided within (7) days after calling.
  ► Preventative/well care - Well care refers to care for those needs which do not restrict a member’s activity (e.g., complete physical, well child care, immunizations, pap and pelvic, etc.). Members needing well care will be seen within (60) days after calling.

► Scheduled appointment wait time
  ► Waiting room wait time will not exceed 30 minutes unless an explanation is provided to the member and they are given an opportunity to reschedule
  ► Exam wait time will not exceed 15 minutes without an explanation

► Courtesy, efficiency and facility
  ► Office staff will demonstrate a sense of professionalism and helpfulness to patients
  ► Phones will be handled so that members are given an option to be placed on hold, calls are returned within 24 hours, and will be answered before 10 full rings
  ► The office is clean, in good repair and has adequate waiting space with comfortable seating
  ► Exam rooms provide privacy for patients and examination equipment is readily accessible
  ► Has easy access to clean, properly supplied bathroom

Provider must meet the credentialing requirements for continued participation as indicated in the HealthSpan Quality Program and HealthSpan Credentialing Program.
Primary Care Physicians

PCPs are responsible for providing and coordinating the medical care of members, and ensuring their continuity of care. PCPs are: General Internal Medicine, General Practice, Geriatric Medicine, Pediatrics and Family Practice. PCPs must provide 24-hour coverage.

A PCP is responsible for:
► Arranging for another HealthSpan participating PCP to provide necessary coverage. Hospital emergency rooms are not acceptable substitutes for covering providers.
► Coordinating the medical care with necessary specialists.
► Twenty-four hour healthcare coverage

Specialty Care Physicians

SCPs are responsible for providing medical care of members through self-referral or PCP referral. SCPs are American Board of Medical Specialty (ABMS) specialists excluding: Internal Medicine, General Practice, Geriatric Medicine, Pediatrics and Family Practice.

Specialty Care Physicians are responsible for:
► Fully cooperating with any utilization review or case management programs developed by HealthSpan to promote high standards of medical care and control costs.
► Twenty-four hour healthcare coverage

Ancillary Providers

Ancillary providers include those providers who render non-physician services related to care (i.e., laboratory, durable medical equipment, home health care, physical or occupational therapy, etc.).

Provider must meet the credentialing requirements for continued participation as indicated in the HealthSpan Quality Program and HealthSpan Credentialing Program.
Provider Directory

The HealthSpan Provider Directory can be accessed through the internet address: www.healthspannetwork.com

Laboratory Services

If a HealthSpan member requires laboratory services, the following options are available within the plan:

1. Offices may give the patient a prescription to take to any one of the approved participating hospitals or ancillary locations to have their lab work completed.

2. Offices that provide phlebotomy services may collect samples in the office and arrange pick up from a courier service that is associated with a participating lab. (Please call the participating laboratory that your office plans to utilize to arrange for the courier service). The courier service will be available to retrieve samples and provide your office with collection supplies and request forms.

A limited number of tests can, and should, be performed in the physician's office in order to provide accurate analysis in some cases. These tests are those that would expedite patient care by immediate performance, or those that require analysis in an expeditious manner, e.g., blood sugar, urinalysis, and other in-office procedures that require immediate analysis.

Employer groups may elect to contract directly with a laboratory that is not considered a participating HealthSpan laboratory. This is noted on the member's identification card.

Please see participating laboratories on HealthSpan's website at www.healthspannetwork.com.
Hospitals and Facilities

Facilities include any acute, skilled or rehabilitative facility, hospital, ambulatory surgery center, skilled nursing facility or rehabilitation facility (see Participating Provider Network and Responsibilities, Section 3). Provider must meet the credentialing requirements for continued participation as indicated in the HealthSpan Quality Program and HealthSpan Credentialing Program.

Per guidelines set by Medicare and Medicaid Services (CMS) Hospital-Acquired Conditions (HAC), for discharges occurring on or after October 1, 2008, Hospital will not receive additional payment for cases in which one of the conditions described below was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present. As CMS selects additional HACs or modifies HACs, the HAC codes will automatically be updated as of the effective date for CMS’ implementation of such changes. Procedures included but not limited to:

- Catheter-Associated Urinary Tract Infection (UTI)
- Object Left in During Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcers
- Vascular Catheter-Associated Infection
- Surgical Site Infection – Mediastinitis after Coronary Artery Bypass Graft (CABG) Surgery (a specific surgical site infection)
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Falls and Trauma – Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burns, Electric Shock Manifestations of Poor Glycemic Control (Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic
ID Cards

Health benefit plans are tailored to individual employers and payers. Therefore, members may present different ID cards and have varied levels of health benefits. However, ID cards usually essentially contain the following information:

► Name
► Employer Group
► Identification number
► Group and / or plan number
► Address for claims submission
► Submitter ID for electronic filing of claims
► Telephone number for verification of eligibility
► Telephone number for claims inquiries
► Precertification/Utilization information

When providing services, it is important that you and / or your office staff remember to:

► Ask members to present their current ID card at each appointment
► Verify a member’s eligibility for coverage via Third Party Administrator
► Identify the phone number for medical management, utilization management, and / or precertification requirements
► File claims electronically for faster reimbursement and claim tracking

Samples of the ID cards of participating payers included in this section.
This card is for identification purposes only and is NOT a guarantee that benefits are still in force.

Medical Management Logo (if available)
Utilization Management is required for all inpatient admissions, selected outpatient procedures and equipment purchases.
Please Contact at Phone #
This program should be followed or your benefits may be affected.
Please refer to your benefits booklet for detailed information.

For questions or coverage verification contact:

TPA Logo

ID CARD EXAMPLE

FRONT

- HealthSpan Network, HealthSpan Preferred
  Network name or Logo may appear on card front
- Copay arrangements (if applicable) may be on the card front

BACK

- Utilization Management requirements statement on card back
- Electronic Claims filing information-EDI payer number/Submitter ID
Member Eligibility

You and/or your office staff can verify member eligibility by calling the appropriate Third Party Administrator indicated on the member’s identification card.

Please note, possession of an ID card does not guarantee coverage of benefits.

PLEASE REMEMBER, HEALTHSPAN CANNOT VERIFY ELIGIBILITY.

Covered Services

At the time of enrollment, members are given an Evidence of Coverage document. This document is designed to answer most questions that could arise regarding coverage and membership services. If a member has any questions that you are unsure of, please direct the member to contact the Third Party Administrator’s telephone number on the back of their member ID card.

How to Identify a HealthSpan Member

HealthSpan Network and HealthSpan Preferred Network members will have a logo imprinted on their identification card, or will have a logo sticker on their existing member ID card. The card will provide the name of the Third Party Administrator who manages the benefit plan, payment of claims, and the name of the employer who is providing the health insurance coverage.

Benefit Verification

To verify HealthSpan benefits for your patient, please call the benefits verification phone number on the patient’s identification card.

PLEASE REMEMBER HEALTHSPAN CANNOT VERIFY BENEFITS.
Copayments and Deductibles

Patients required to pay an office visit copayment may have the amount due indicated on their identification card. **HealthSpan** members without an office visit copay may be responsible for a portion of the bill due to co-insurance (i.e. 20% co-insurance after deductible has been met).

Please contact appropriate Third Party Administrator for copay or coinsurance amounts if they are not indicated on the member's identification card.
Third Party Administrators (TPAs)

HealthSpan works with several TPAs for the HealthSpan and HealthSpan Preferred Network. You may request a client grid that includes information on where to call regarding claims inquiries, benefit verification, and preauthorization procedures for employers for HealthSpan groups. The TPA information includes the Third Party Administrator name and phone number.
Programs

Medical Management services are performed for selected HealthSpan clients, as identified on the member’s identification card. The following section details the HealthSpan Medical Management program. This program has been accepted by all HealthSpan member hospitals. HealthSpan recommends this program to all of its employer groups. However employers may choose to design their own Medical Management programs.

HealthSpan Complete Care Program services include:

HealthSpan Medical Management department will promote and improve the health of our population. Care Management will empower clients to be appropriate users of healthcare by providing the tools and resources that will engage consumers in the process of lifestyle, health and healthcare self management. Care managers will provide collaboration with the healthcare team for the appropriate setting and timing of care. Care managers will support early identification of health issues and encourage members to take an active and informed role in their healthcare decisions.

Outpatient Management Program

Call (513) 551-1420 or 1-800-972-7726 for precertification of outpatient services

Medical Management precertification to verify HealthSpan requirements – please call the Medical Management phone number on the patient’s identification card.

Certification and on-going monitoring of select outpatient care is focused on:

- Assuring medical necessity of the service
- Encouraging the use of HealthSpan participating providers
- Coordinating the use of cost-effective, quality alternatives to more costly levels of care
- Monitoring the quality of outpatient care/services by screening for sentinel events and member satisfaction.
MEDICAL MANAGEMENT PROGRAM

The primary features of outpatient medical management are:
► Surgical necessity review of outpatient surgery using established protocols
► Medical necessity review (prospective and retrospective) of such services as but not limited to home health, durable medical equipment, physical therapy, occupational therapy, speech therapy, chiropractic care and pain management programs
► Continuous monitoring of service used to provide administrative assistance in coordination of care, services and benefits for the patient and physician
► Identification of members appropriate for specific case management and/or disease management programs

Inpatient Management Program

Call (513) 551-1420 or 1-800-972-7726 for precertification/notification of inpatient stays

Inpatient management is designed to:
► Ensure services are rendered at the appropriate level i.e. acute, rehabilitation or skilled nursing facility and eliminate unnecessary admissions
► Encourage use of HealthSpan participating providers
► Monitor lengths of stay of medically appropriate admissions
► Coordinate the use of cost-effective, quality alternatives to inpatient care when appropriate
► Monitor the quality of inpatient care by screening for unusual events which might indicate a compromise of quality of care and/or periodically screening for compliance to clinical protocols or critical pathways.

The primary features of inpatient medical management are:
► Pre-admission review of elective admissions using established criteria and length of stay guidelines
► Medical necessity review of emergency admissions and those elective admissions not receiving pre-admission review to determine appropriateness of the inpatient setting
► Continued stay review to monitor the need for further hospitalization and screen for quality indicators
► Discharge planning to identify quality, cost-effective alternatives to hospitalization and provide administrative assistance in implementation of a discharge plan agreed upon by the physician and patient
► Identification of members appropriate for specific case management and/or disease management programs
MEDICAL MANAGEMENT PROGRAM

Case Management Program

Call 513-551-1420 or 1/800-972-7726 for case management referrals

Case Management is a proactive approach designed to provide support to members with complex or chronic diagnoses with an acute episode or issue requiring coordination or monitoring of services such as therapies, home care, DME, specialty clinic, specialist, etc and involves a compliance issue, knowledge deficit or need for emotional support. This involves collaboration with the individual and physician. Interventions are aimed at keeping membership healthy, improving their health, and/or helping them accept and live more productive lives with chronic disease. Quality, holistic care plans are developed in partnership with participating providers. These focused care plans are time specific and action oriented with total health management in mind.

► Coordination of resource allocation, including network management activities necessary to accomplish effective health care outcome
► Communication with physicians and other health care providers to link all levels of care
► Facilitation of common goals for members, families and providers
► Health of membership is improved in a measurable, reportable way

Disease Management Program

Disease Management is a population-based strategy for ensuring that all members with targeted chronic disease where risk factors can be reduced with lifestyle changes and compliance with evidence based medicine are evaluated and supported in optimizing self-management techniques. The goals of Disease Management are to manage the disease process in order to minimize the occurrence of complications and the need for costly medical intervention in the future.

Diseases Generally Targeted for Disease Management Include:
► Hypertension
► Diabetes
► Coronary Artery Disease
► Congestive Heart Failure
► Chronic Obstructive Pulmonary Disease
► Asthma
► Depression
► Hyperlipidemia
MEDICAL MANAGEMENT PROGRAM

The Process of Disease Management Include:
► Evaluation of current Stage in Disease
► Evaluation of Medical Screening Schedule
► Evaluation of Behavioral and Lifestyle Risk Factors
► Evaluation & Engagement of Family and Support Systems
► Providing Education on the Disease Process
► Providing Education on Self-Management Tools
► Goal Focused Health Contracting

Wellness Promotion
► Medical Management will facilitate wellness screenings and provide follow-up and support

Provider Medical Necessity Determination
Reconsiderations

Medical necessity determination reconsiderations may be submitted directly to HealthSpan via fax (513) 551 1439 or (513) 551 1438. Reconsiderations must be made in writing, directly from a provider, and should include all information relevant to making the medical necessity determination. The reconsideration must be submitted within thirty days of the denial. Please call the HealthSpan Care Management Department at (513) 551-1420 or (800) 972-7726 for questions regarding additional information that is helpful in making specific determinations. HealthSpan provides one level of reconsideration for providers. The reconsideration request and attached information will be reviewed and the provider will be notified within 30 days of the decision.

Key Medical Management Contacts

*Please see Section II for Key Contact List.
Claims Submission

Claims are to be sent to the appropriate address identified on the member's identification card.

**HealthSpan** requires that the physician file the patient's claim.

**Claims must be filed within 60 days** from date of service or reimbursement may be denied. The claim should be submitted electronically in 5010 format. If a paper claim submission is needed, please submit all physician charges on a standard CMS-1500 form. Submit all inpatient and outpatient facility charges on a standard UB-04 form if filing a paper claim. The claim must include the group number and employer group name. This information will be on the patient's identification card. Missing information will delay adjudication and may cause the claim to reject.

Claims are processed by the employee's Third Party Administrator (TPA). Please call them with any questions about a specific claim.

Guidelines

All claim fields must be completed when submitting claims. Claims should be submitted electronically in 5010 format. When a paper claim is required the most current version of the 1500 or UB should be used. Please follow the industry-standard instructions published by the authors of the forms to determine appropriate completion. In addition:

- Verify that a member's name and ID number is entered exactly as it appears on the member's ID card
- Verify that the group number listed on the member's id card is listed on the claim
- List dates of service in chronological order, with separate charges itemized on separate lines
- Attach an operative, radiology or pathology report to claims with unusual or extended procedures
- Provide concise descriptions of unlisted or not otherwise classified (NOC) procedure codes
- Identify the applicable modifiers, which comprise the use of a 99 modifier
- Submit a different claim form for each provider and member
- Submit claims with an Explanation of Benefits (EOB) from the primary carrier when the member has other insurance coverage and that carrier is the primary carrier
- Identify the individual provider of the service
- Electronic claims should be submitted to the location indicated on the member's card.
- Paper claims should be directed to the address indicated on the member's ID card and only when electronic submission is not possible.
Claims Inquiries

Providers with claim inquiries should contact the appropriate Third Party Administrator indicated on the member's identification card. When making an inquiry, please have the following information available:

► Provider name and tax id number
► Member name and ID number
► Date of service
► Claim number
► Employer group name or number

Reimbursement

All providers are reimbursed in accordance with your HealthSpan Participation Agreement.

Any questions concerning claim status, denials, request for information or potential payment error should be directed to the TPA that adjudicated the claim.

Coordination of Benefits

1. If HealthSpan is not the primary carrier, the physician may hold the HealthSpan claim until payment from the primary carrier has been received. At that time, the Explanation of Benefits (EOB) and claim should be submitted to the appropriate TPA for claim adjudication.
2. Providers must abide by the Third Party Administrators rules regarding Coordination of Benefits.
3. The payment will be made based on the Coordination of Benefits language identified in each Summary Plan Description.

Claims Appeal Process

Each Provider is entitled to a full and fair review of any denial of a claim or claim payment issue. Please contact the appropriate Third Party Administrator for their claim appeal process for all claim and payment related issues. Claim appeals must be submitted in writing within one year of the explanation of benefits.
HealthSpan is committed to meeting and exceeding the expectations of its providers. HealthSpan investigates all disputes in a timely manner and attempts to resolve them at the provider relations level. If a problem cannot be resolved, a formal Grievance Procedure is available to members and providers.

**Procedure:**

A provider dispute is defined as a complaint initiated by a provider that is not a claim dispute. Staff can resolve most complaints before reaching the first level of a Formal Grievance. Most grievances may be submitted verbally or in writing.

Network Services staff receiving complaints will make all efforts to resolve the complaint at the time that the complaint is made. The network services staff member receiving the call documents all verbal complaints and any actions taken to address the complaint. Non-clinical provider complaints will be referred to the Director of Network Services.

If the complaint has not been resolved within sixty days, the complaint will be considered a Formal Grievance. The Director of Network Services will initiate requests for information, both internal and external.

Written acknowledgement of the grievance will be provided to the provider who includes his/her option to appeal to the first level appeal committee.

After all records and documents have been obtained, the file will be summarized sent to the Level I Appeal Committee for review and disposition.

Level I Appeal Committee will notify the provider of review outcome within fifteen working days of the decision. The Level One Appeal Committee consists of at least one participating provider not involved in network services.

The provider must notify HealthSpan of a request for a second level of appeal within fifteen working days of receipt of the Appeal Level I Committee decision.

Level II Appeal Committee is the final dispute resolution committee, which consists of at least three individuals that comply with the requirements of the initial appeal level panel.

Level II Appeal Committee must notify the provider of the outcome within fifteen working days.

*Disputes among parties to a healthcare contract that only concern the enforcement of contract rights conferred by Ohio Rev Code 3963.02 divisions (A) and (D) of section 3963.03 and section 3963.04 are subject to mutually agreed upon arbitration that is binding to all parties.*