PROVIDER MANUAL

WPS HEALTH INSURANCE

Local. Honest. Independent.

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INTRODUCTION

Wisconsin Physicians Service Insurance Corporation (WPS Health Insurance or WPS) is pleased to welcome you as a partner!

The WPS Provider Manual is designed and produced for WPS preferred providers to promote a clear understanding of our policies and procedures, including provider services, prior authorization, claims, and eligibility.

The purpose of this manual is to answer some of the questions you may have regarding WPS operations. As changes occur, this manual will be updated on a routine basis. When accessing the Provider Manual, please refer to our website for the most current information. WPS reserves the right to revise or alter the material and information detailed in this manual at any time.

About WPS

WPS Health Insurance is a leading Wisconsin not-for-profit insurer offering affordable individual health insurance as well as flexible group health plans and cost-effective claims administration for businesses.

WPS Health Insurance offers a broad range of health insurance products designed to meet our members' changing needs—from individual and family health plans to individual Medicare supplement plans, individual Medicare Part D prescription drug plans, group health plans, self-funded group health plans, and more. As a company, we strive to provide innovative products and services, promote the health and wellness of our employees, and support the communities we serve.

Insuring Wisconsin's Health Since 1946

WPS Health Insurance has deep Wisconsin roots grounded in events that transformed health care practices in the United States. The Great Depression exposed the financial vulnerability of health care providers throughout the United States, encouraging them to turn to health insurance as a solution. Responding to concerns, legislators authorized the State Medical Society to establish not-for-profit health insurance plans.

In 1946, the State Medical Society established Wisconsin Physicians Service (WPS) to market an insurance product known as the Wisconsin Plan. This plan collected low monthly premiums and reflected the State Medical Society's belief that Wisconsin residents should have meaningful choices in health care providers.

More than 70 years later, WPS is more committed than ever to top-tier service. Our customers deserve our best effort, and we must keep the promises we make. Today, WPS leads the healthy conversation for the health and financial protection of its members.

Statewide Provider Network

The WPS Statewide Network is a broad network ideal for groups with employees throughout the state. Employees enjoy convenient access to a wide range of

providers across Wisconsin. Anyone covered under the WPS Statewide Network can enjoy in-network benefits when they visit participating out-of-state providers through our National Network Wrap. The WPS Statewide Network is also available to individual health plan members.

We round out our product offerings through our wholly owned subsidiaries, Arise Health Plan and EPIC Specialty Benefits. Arise Health Plan, based in De Pere, builds comprehensive and affordable health plans for individuals and families, as well as groups. Business customers can choose from flexible, cost-effective group plans and competitive claims administration, as well as life, disability, dental, vision, and voluntary benefits from EPIC Specialty Benefits.

CONTACT WPS

Corporate

Mailing Address	P.O. Box 8190 Madison, WI 53708
Office Address	1717 W. Broadway Madison, WI 53713
Phone	800-223-6048
Business Hours	Monday through Friday, 7:30 a.m. to 5 p.m. CT
Website	wpsic.com

Provider Services—provider dedicated customer service line

Phone	800-765-4977
Fax	608-223-3626
Email	member@wpsic.com
Hours	Monday through Thursday, 7:30 a.m. to 5 p.m. CT Friday, 8 a.m. to 4:30 p.m. CT

Contact Provider Services for:

- Eligibility verification
- Network participation
- Claim status
- Benefit information
- Becoming a WPS preferred provider

Claims Filing Address:
Wisconsin Physicians Service
P.O. Box 21341
Eagan, MN 55121

Claim Correspondence Address (Questions on claim processing or payment):
Wisconsin Physicians Service
P.O. Box 8190
Madison, WI 53708

Provider Relations

Fax 608-977-9939

Contact the Provider Relations team for:

- Fee schedule inquiries
- Provider contracts
- Provider directory/website listings
- WPS reimbursement policies

Northwestern/North-Central Wisconsin

Stacy Willems, Provider Network Coordinator
608-977-6697
Stacy.Willems@wpsic.com

Janis Roesslein, Provider Relations Director
608-977-6661
Janis.Roesslein@wpsic.com

Northeastern Wisconsin

Karen Kabat, Health Plan Manager
920-490-6993
Karen.Kabat@wpsic.com

Kathy Stephenson, Provider Relations Director
920-617-6320
Kathy.Stephenson@wpsic.com

Southwestern/South-Central Wisconsin

Lori Olivares, Provider Network Coordinator
608-977-6643
Lori.Olivares@wpsic.com

Jayne Thompson, Health Plan Manager
608-977-6688
Jayne.Thompson@wpsic.com

Southeastern Wisconsin

Jessie Evans, Provider Network Coordinator
608-977-6582
Jessie.Evans@wpsic.com

Amy Anderson, Provider Relations Director
920-490-6930
Amy.Anderson@wpsic.com

Provider Credentialing

Credentialing Manager
920-490-6952 (Direct)
Senior Credentialing Specialist
920-490-6954 or 608-221-5479 (Fax)
GBCredentialingDept@AriseHealthPlan.com

Contact Provider Credentialing with questions concerning:

- Initial credentialing
- Re-credentialing

Independent Chiropractors

Please contact Magellan Healthcare directory regarding contracts and/or credentialing.

Magellan Healthcare
7805 Hudson Road, Suite 190
St. Paul, MN 55125

Main Phone	952-225-5700
Toll-Free	800-432-3640
Fax	888-656-1913

Integrated Care Management

Direct	800-333-5003
Toll-Free	800-333-5003
General Fax	608-226-4711
Prior Authorization Fax	608-226-4777

Contact Integrated Care Management for:

- Pharmacy management
- Medical policies
- iExchange electronic prior authorization request
- Outpatient and elective inpatient pre-certification guidelines (inpatient hospital or skilled nursing facility)
- Outpatient behavioral health treatment request

Electronic Data Interchange (EDI) Department

The WPS Corporate Services—EDI department has a dedicated team whose primary function is to consult and serve providers regarding Electronic Data Interchange (EDI) issues. Our team is experienced in dealing with a variety of provider specialties, billing services, and software vendors.

Phone	608-221-7115
Toll-Free	800-782-2680, Option 1
Email	edi@wpsic.com
Web	wpsic.com/edi
Hours	Monday through Friday, 7:55 a.m. to 4:30 p.m. CT

PRODUCT AND BENEFIT PLANS

With high-quality coverage, affordable plan designs, and the ability to offer a range of benefit choices, WPS offers a wide array of plans to meet every need. We provide claims administration to self-funded group health plans and insure individuals, families, and employers. Group plan benefit options vary depending on whether or not the group is self-funded.

Below is an overview of the plan options offered by WPS.

Preferred Provider Organization (PPO)

A Preferred Provider Organization plan (PPO) is defined by Wisconsin statutes and offers broad freedom of provider choice. Members of PPOs are free to receive care from in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers within their defined PPO network. Payments to out-of-network providers are subject to fee limitations.

Copay Plans

These plans allow choice of a wide range of deductibles, coinsurance, and per-visit copayment options. Our prescription drug benefit features tiered copayments to maximize cost efficiency and value.

Health Savings Account (HSA) Plans

These plans allow members to open a health savings account that lets members budget and pay for qualified medical expenses using tax-free dollars.

Network Options

WPS' provider networks offer convenient access to the physicians and health care facilities Wisconsin residents know and trust. Choose from our comprehensive WPS Statewide Network, cost-effective local and regional networks, and a national wrap network.

Southern Network

The localized Southern Network features SSM Health and St. Mary’s Hospital. Available in the following counties: Adams, Dodge, Iowa, Richland, Columbia, Grant, Jefferson, Rock, Dane, Green, Lafayette, and Sauk.

HealthyU Network

The localized HealthyU Network features University of Wisconsin Hospital and Clinics and UW Medical Foundation providers. Available in the following counties: Adams, Dodge, Iowa, Richland, Columbia, Grant, Jefferson, Rock, Dane, Green, Lafayette, and Sauk.

WPS Statewide Network

The regional WPS Statewide Network includes more than 25,000 health care service locations, a wide range of clinics and specialty care centers, and 165 hospitals throughout Wisconsin, as well as parts of Illinois, Iowa, and Minnesota.

First Health/SelectCare Wrap Network

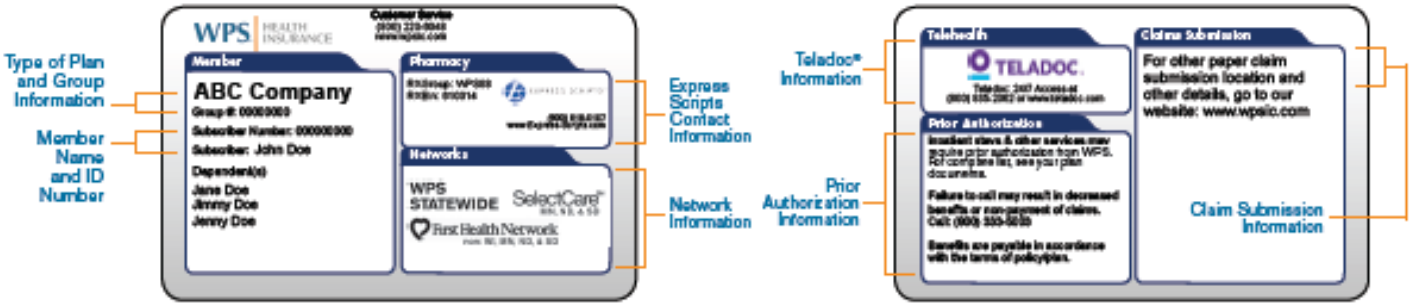
The national First Health/SelectCare Wrap Network covers all 49 states outside of Wisconsin. This network features more than 1 million service locations, 5,000 hospitals, and 90,000 ancillary facilities throughout the nation.

Wisconsin Medicare Supplement (Medigap) Health Insurance Plans

Medicare supplement health insurance plans are regulated by the Wisconsin Office of the Commissioner of Insurance (OCI). WPS Medicare supplement plans meet OCI standards and offer a core set of benefits and riders that help cover the Medicare deductible and coinsurance.

MEMBER IDENTIFICATION (ID) CARDS

WPS members receive ID cards containing information needed by providers to check WPS eligibility and benefits, as well as submit claims. The ID card includes the member name, member ID number, the group number, and WPS contact information. WPS member ID numbers are randomly generated.



MEMBER RIGHTS AND RESPONSIBILITIES

The Member Rights and Responsibilities listed below set the framework for cooperation among members, practitioners, and WPS.

MEMBER RIGHTS

- To be treated with respect and recognition of their dignity and right to privacy.
- To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To participate with practitioners in making decisions about their health care.
- To receive information about us, our services, our network of health care practitioners and providers, and their rights and responsibilities.
- To voice complaints or appeals about us or the care we provide.
- To make recommendations regarding the members' rights and responsibilities policies.

MEMBER RESPONSIBILITIES AS A HEALTH PLAN MEMBER

- To supply information (to the extent possible) that we and our practitioners and providers need in order to provide care.
- To understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To follow the treatment plan and instructions for care that have been agreed on with their practitioners.

MEMBERS' PROTECTED HEALTH INFORMATION

WPS uses and discloses health information about members for payment and health care operations, and for their treatment. Health care operations include efforts to track our quality improvement activities.

Members may give us written authorization to use their health information, or to disclose it to anyone, including themselves, for any purpose. If members give us an authorization, they may revoke it at any time. We may disclose a member's health information to a family member, friend, or other person to the extent necessary to help with the member's health care or with payment for health care. In the event of a member's incapacity or an emergency, we will disclose their health information based on our professional judgment of whether the disclosure would be in the member's best interest.

Members have the right to look at or receive copies of their health information, with limited exceptions. Please refer members to our website for additional information.

We are committed to protecting the confidentiality and privacy of every aspect of service and care across the organization. We have developed, implemented, maintained, and used appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information and prevent intentional or unintentional use or disclosure in violation of law.

We may disclose summary information about the participants in a member's group health plan to the plan sponsor in order to obtain premium bids for health insurance coverage. This summary information is stripped of any personal information and contains only general statistics about the types and costs of claims.

If you want more information about our privacy practices, or have questions or concerns, visit our website, wpsic.com, or contact our Privacy Officer at WPS, Privacy Office, 1717 W. Broadway, P.O. Box 8190, Madison, WI 53708-8190; WPSprivacyofficer@wpsic.com; or 608-977-7500.

MEMBER GRIEVANCE/APPEAL PROCESS

This section includes the grievance and appeal rights and procedures for covered persons of plans that are governed by the Employee Retirement Income Security Act of 1974 (ERISA). Members of ERISA plans have the right to file a civil action under Section 502 (a) of ERISA if a health plan fails to establish or follow claims procedures, or after all appeals outlined in this section have been completed. Typically, the term *grievance* is used to refer to requests for review under fully insured plans, while *appeal* is used to describe requests for claim review under self-funded plans. This section refers to *grievances* as shorthand for *grievances* and *appeals*.

A grievance is any dissatisfaction with the administration, claims practices, or provision of services by WPS that is expressed in writing to the WPS Grievance department, by, or on behalf of, a covered person.

The Grievance Committee is composed of three voting members from various WPS departments, plus a medical advisor, a legal advisor, and a provider reimbursement advisor.

If the Committee's medical advisor believes they do not have the relevant experience or knowledge to render a medical opinion on a case, it will be sent to an external review organization for evaluation by a qualified specialty reviewer.

Any covered person or his/her authorized representative who files a grievance will be notified of his/her right to appear in person, or to present written or oral information before the Grievance Committee. WPS will send the covered person written notice of the time and place they may appear before the Grievance Committee. Following a thorough review of all information received for the grievance, the Grievance Committee votes on the resolution of the case. A resolution letter outlining the Grievance Committee's decision is sent following the meeting.

Grievances are resolved within 30 calendar days, unless the covered person gives permission for a 30-day extension. If the person’s medical condition warrants, the grievance may be expedited and resolved within 72 hours.

Requesting a Grievance

Only a WPS member or his/her authorized representative may request a grievance on a claim or medical decision. The attending provider, or facility rendering service, may submit a grievance, but ONLY with signed authorization from the patient.

The patient must sign and submit the Grievance Authorized Representative Form if he/she wants a provider or another individual to appeal on his/her behalf.

Urgent or Expedited Grievance

An Expedited Grievance refers to a grievance where any of the following applies:

- The duration of the standard resolution process will result in serious jeopardy to the patient’s life or health or the patient’s ability to regain maximum function

- In the opinion of a physician with knowledge of the medical condition, the patient is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance
- A physician with knowledge of the patient's medical condition determines that the grievance shall be treated as an expedited grievance

Independent Review Process

The independent review process provides members with an opportunity to have an independent review organization (IRO) review their dispute. An IRO will be randomly selected by WPS to review the dispute. Only disputes that involve medical judgment can be decided through independent review. Members may request an independent review if they were denied coverage for treatment because we have determined that the treatment is primarily for one of the following:

- Cosmetic purposes
- Not medically necessary
- Experimental
- Investigative

This includes the denial of a referral request if the member has a provisional referral benefit on their PPO plan. Members may also request an independent review if they disagree with our determination regarding the diagnosis and level of service for treatment of autism. The treatment must be a covered benefit under the insurance contract; benefits specifically excluded from the member's benefit contract are not eligible for independent review.

Within four (4) months after receiving notice of the disposition of their grievance, members may send a written request for an independent review to:

Wisconsin Physicians Service Insurance Corporation
Attention: IRO Coordinator
P.O. Box 7458
Madison, WI 53707

Office of the Commissioner of Insurance (OCI)

In addition to a WPS grievance/appeal, members may also contact the Office of the Commissioner of Insurance (OCI), a state agency that enforces Wisconsin's insurance laws, and file a complaint. OCI can be contacted by writing to:

Office of the Commissioner of Insurance
Complaints Department
125 South Webster Street
P.O. Box 7873
Madison, WI 53707-7873

Local Phone:	608-266-0103
Toll-Free:	800-236-8517 (within WI)
Fax:	608-264-8115
Website:	oci.wi.gov

CREDENTIALING

WPS will credential practitioners who have an independent relationship with WPS. An independent relationship exists when WPS selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners who can be selected as primary care practitioners. Once approved, an ongoing assessment (re-credentialing) is conducted at least every three (3) years.

Practitioner Credentialing

Credentialing and re-credentialing is required of the following professionals:

Doctors

- Medicine (MD)
- Osteopathic Medicine (DO)
- Podiatric Medicine (DPM)
- Chiropractic (DC)
- Optometry (OD)
- Doctors of Dental Science (DDS)/Doctors of Medical Dentistry (DMD) who provide care under the medical benefit program

Behavioral Health Care Practitioners

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or Master's level Clinical Psychologists (Ph.D. or Psy.D.)
- Master's level clinical nurse specialists or psychiatric nurse practitioners (NP, APNP)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Professional Counselors (LPC)
- Licensed Social Workers (APSW, ISW, LCSW)
- Substance Abuse Counselors (SAC, CSAC)
- Master's Level Counselors (M.A., M.S., M.S.E., M.S.W.)
- Licensed Behavior Analysts (LBA)

Allied Health Professionals

Allied Health Professionals who are not facility-based providers, including, but not limited to:

- Advanced Practice Nurse Prescribers (APNP)
- Master's Level Nurse Practitioners (NP, FNP, WHNP, etc.)
- Certified Nurse Midwives (CNM)
- Physician Assistants (PA or PAC)
- Audiologists (AuD)
- Registered Dietitians (RD)
- Physical Therapists (PT)
- Speech and Language Pathologists (SLP)
- Occupational Therapists (OT)

Other Professionals

- Allied health professionals who have an independent relationship with WPS and are not part of an organization or group of practitioners.
- Covering practitioners (*locum tenens*) providing services for a period longer than six (6) months.
- Practitioners who are hospital-based but who see members outside of the inpatient hospital setting, or free-standing, ambulatory facilities as a result of their independent relationship with WPS (e.g., pain medicine, radiation oncology).
- Rental networks that are part of the WPS network and have members who reside in the rental network area OR are specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners.
- Telehealth practitioners who provide care to members under WPS medical benefits.

Organizational Provider Credentialing

WPS also conducts a pre-contractual assessment of each organizational provider with which it contracts and performs an ongoing assessment at least every three (3) years.

Organizational providers include:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Hospices
- Free-standing surgical centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory center
- Dialysis centers
- Clinical laboratories
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Portal X-ray supplies
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

WPS will confirm that the organizational provider:

- Meets all state and federal licensing and regulatory requirements in good standing
- Has proof of adequate liability insurance
- Has evidence of accreditation or site visit by a recognized accrediting body or current CMS certification

Provider Credentialing Rights

The decision to credential or re-credential a practitioner is based on the information assembled, including, but not limited to, the information gathered

through a completed application and primary source verification. Credentialing/re-credentialing criteria are used to establish consistent, clear objectives for the credentialing/re-credentialing of practitioners. The credentialing/re-credentialing decision to approve or deny the applicant is determined by the Credentials Committee. WPS credentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes. This does not preclude WPS from including in its network practitioners who meet certain demographic or specialty needs.

During the credentialing process:

- You may request information regarding the status of your application at any time.
- You will be promptly notified of information that varies significantly from the information you have provided, and you will be given the opportunity to submit updated/additional documentation or corrections.
- Notification of the Credentials Committee decision regarding your application will be sent via written letter promptly after the meeting at which your application is presented.

Note: Approval of your credentialing application **is not indicative of contract effective date.** Contact the Network Development Department at 888-711-1444 or email GBNetworkDevelopmentDept@AriseHealthPlan.com for your official effective date.

CLAIMS PROCEDURES

Electronic Claim Submissions

WPS Health Insurance strongly recommends submitting claims electronically in order to expedite claim processing. This submission format is available for situations in which WPS is the primary as well as the secondary carrier.

The WPS Corporate Services—EDI department has a dedicated team whose primary function is to consult and serve providers regarding Electronic Data Interchange (EDI) issues. Our team is experienced in dealing with a variety of provider specialties, billing services, and software vendors.

Contact EDI

Providers interested in becoming an EDI trading partner with WPS should contact our EDI team. See the EDI under the Contact WPS section of this manual.

Paper Claim Submissions

If you choose to submit paper claims, the claim must be submitted using industry-standard formats, on industry standard forms, using the required specific code set as promulgated by HIPAA. The claim submission must communicate all of the following required elements to ensure accurate and timely claim payment:

- Who was treated and why
- Services provided
- Date of service
- Amount billed for those services
- Where those services were rendered
- Who rendered those services

The above data are also essential for state, national, and accrediting body reporting requirements.

Coding Requirements

- Healthcare Common Procedure Coding System (HCPCS) for Ancillary Services/Procedures
- Code on Dental Procedures and Nomenclature (CDT)
- Current Procedural Terminology (CPT-4) for Physicians Procedures
- International Classification of Diseases, ICD-10 for dates of service Oct. 1, 2015, and thereafter
- National Drug Codes (NDC)
- Codes maintained by the National Uniform Billing Committee (NUBC) for institutional use
- National Provider Identifier (NPI)
- Taxonomy
- Other specific coding requirements as determined by the standard format

All codes billed must be appropriate and active for the specific date of service billed. If a code has been deleted or is not appropriate for the service, the claim and/or claim line will be automatically denied.

Industry-Standard Claim Forms

- National Uniform Claim Committee (NUCC) CMS-1500 Health Insurance Claim Form
- The CMS-1450 (UB-04)

Please refer to the NUCC and CMS-1450 completion standards for details on field definitions and requirements.

Claims Filing Address

Paper claims should be submitted to the following claims filing address unless otherwise stated on the member's ID card:

WPS Health Insurance
P.O. Box 21341
Eagan, MN 55121

A new, original claim form must be submitted to WPS along with any additional data requested to ensure the claim will be accepted and processed.

All unreadable or noncompliant forms will be returned with a letter explaining the reason the claim cannot be accepted. A copy of the claim as originally submitted will also be attached to assist you in correcting the errors.

Hospital-Acquired Conditions

WPS follows CMS' current and future recognition of hospital-acquired conditions. Current and valid Present on Admission (POA) indicators (as defined by CMS) must be populated on all inpatient acute care facility claims. When a hospital-acquired condition occurs, the inpatient acute care facility shall identify the charges and/or days which are the direct result of the hospital-acquired condition.

Medical Records and Completion of Care Plans

Provider should allow WPS, or any state or federal regulatory agency as required by law, to have reasonable access to provider administrative records as they relate to services provided under an applicable PPO Agreement, including, but not limited to, access to documentation pursuant to applicable Wisconsin Administrative Code.

Reasons medical records may be requested include, but are not limited to:

- Utilization or care management reviews
- Quality improvement programs
- Provider or member complaints
- Member grievances/appeals
- Internal and external claim audits
- Pre-existing conditions (grandfathered plans)

Timely Filing of Claims

If you are a WPS-contracted preferred provider, please refer to your WPS Preferred Provider Agreement for timely filing provisions. Claims must be received within the time frame specified, so please submit as soon as possible following the date of service to expedite the claim payment process.

The timely filing period for coordination of benefits (COB) claims begins from the date of the primary payer's EOB. WPS is not obligated to pay claims received after the timely filing provisions of the WPS Preferred Provider Agreement or the member's benefit plan.

Claim Editing (CES)

WPS uses CES software to automatically review claim submissions for appropriate claim coding. This includes edits for procedures that are age-specific, bundling/unbundling, global billing and follow-up services, and thresholds for billed units. CES reviews may result in an adjustment of the claim and/or payment as a result of the rules contained within the CES software.

WPS provides an online tool for providers to simulate code combinations for professional services billed on a HCFA 1500 claim form. It offers the capability to view edit results and rationale. Providers can enter procedure codes, modifiers, diagnosis codes, date of service, patient gender, date of birth, and place of service parameters

to review results specific to the procedure codes being billed. The results and rationale will be displayed and can be downloaded as a PDF. This online tool allows greater transparency of the code combination edits applied by WPS.

This web application is available to all contracted providers through the Provider Portal on wpsic.com/providers.

To register for a Provider Portal account, send an email to register@wpsic.com with the following information: administrator name, email address, tax ID, and practice name. Once your account is set up, the Site Administrator Guide and the Sub Users Guide can help walk you through the various site areas.

Reimbursement Policies

To view our reimbursement policies, please visit **wpsic.com**, click on the **Providers** tab, and then **WPS Reimbursement Policies**.

Subrogation

To the extent permitted under applicable state and federal law, and the affected member's benefit plan, WPS reserves the right to recover benefits paid for a member's health care service when a third party causes the member's illness or injury.

Coordination of Benefits (COB)

Coordination of Benefits is administered according to the member's benefit plan and applicable laws. We accept and encourage secondary claims to be filed electronically. Please do not submit claims that will cross over from Medicare electronically; this will create duplicate claim errors.

Workers' Compensation

Most WPS benefits plans do not cover services for illness or injuries obtained while performing tasks for wage or profit. In cases where an illness or injury is employment-related, workers' compensation is primary, and the claim should be filed with the member's workers' compensation carrier. If notification is received from the workers' compensation carrier that the claim for services has been denied, the provider should submit the claim to WPS so the applicable plan benefits may be considered, even if the case is being disputed. The timely filing limit will be calculated using the date of the workers' compensation denial.

Claim Audits

WPS claims payment integrity includes evaluation of the appropriateness of pre- and post-paid claims. We may conduct a systematic audit of paid claims for institutional, professional, and other types of providers who submit claims to WPS. This audit may include reviewing medical records to substantiate billed charges. The results of these audits may require adjustments to payments and/or requests for reimbursement of paid claims.

Special Investigations Unit (SIU)

The WPS Special Investigations Unit (SIU) is responsible for investigating claims for the potential of fraud and abuse. These investigations may be initiated based on allegations or referrals, or by random or targeted claim reviews. The mission of SIU is to investigate, identify, prevent, and report fraud and abuse in the claims billing process. We may also request and recover money that has been paid as a result of identified fraud or abuse.

Examples of fraud or abuse include:

- Using another person's ID card to obtain or bill for medical services.
- Billing for a medical service or equipment that was not provided.
- Billing for higher-level services than necessary to receive additional reimbursement when a lower-level service was performed.

Overpayments

If you identify a claim for which an overpayment has occurred by WPS, or if we inform you in writing of an overpayment WPS has made, you will be required to send us the overpayment identified or requested within thirty (30) calendar days or by the time limit specified in your WPS Preferred Provider Agreement.

Claim Correction/Resubmission

Electronic Claim

On occasion, you may need to correct a claim that was already filed with WPS electronically. When you refile the claim electronically, be sure to use the appropriate bill type for the services provided, along with the original claim identification number supplied on the 835 remit. This will help expedite the reprocessing of a corrected claim and help reduce the time it will take to finalize the claim.

When submitting corrected claims electronically:

- Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in the CLM*05 03.
- Enter the original claim number in the 2300 loop in the REF*F8*.

If you are unsure of the correct bill type to use, please refer to your HIPAA implementation guide for institutional and professional claims. Remember to refile the claim using the WPS original claim identification number referenced on your 835 remit.

Paper Claim

When submitting a corrected claim via paper submission, include the Corrected Claim Cover Sheet found on the Provider Forms area of our website. Be sure to use the appropriate bill type for the services being provided in box 4 of the UB form and box 22 of the HCFA form. This will allow us to process your corrected claim in a more timely manner. Paper corrected claims sent without the cover sheet will be returned to you.

If you are unsure of the correct bill type to use, please refer to your HIPAA implementation guide for institutional and professional claims. Remember to refile the claim using the WPS original claim identification number referenced on your 835 remit.

Claim Disputes

If you feel a claim has not been paid correctly, or that services have been inappropriately denied, you or the member have the right to ask for a review of the claim.

Please send supporting documentation and any correspondence to our Member Services Department at:

Wisconsin Physicians Service Insurance Corporation
PO Box 21341
Eagan, MN 55121

MEDICAL POLICIES AND PROCEDURES

Medical Policies provide guidelines for determining coverage for specific medical technologies and/or procedures. The principal component of the medical policy development and review process is to evaluate new and existing medical technologies, procedures, pharmaceuticals, devices, and criteria for use in medical necessity and experimental/investigational determinations. The WPS Medical Policy Committee is responsible for the development of internal medical policies.

The goal of the Medical Policy Committee is to ensure that the Medical Policies are: (a) reviewed on a regular basis; (b) consistent with the most current, evidence-based scientific literature; and (c) in line with accepted standards of medical practice.

Providers may obtain the Medical Policy guidelines used for making medical coverage determinations for a WPS member under their care. Medical Policies are available on our website at WPS Medical Polices. For member-specific requests, include the member name and member number along with the procedure, service, and/or treatment for which you are requesting the Medical Policy guideline. Requests may be submitted via phone, fax, or in writing to:

WPS
Attn: Medical Affairs Department
1717 W Broadway, PO Box 8190
Madison, WI 53708-8190
Phone: 800-333-5003
Fax: 608-226-4777

If you have comments or suggestions regarding specific guidelines, you may email WPS Medical Affairs at medical.policies@wpsic.com.

iExchange® Web Portal

iExchange® is a web-based tool offered by WPS that allows clinical staff to electronically submit prior authorization requests for inpatient and outpatient services to WPS via the internet in a secure environment.

We strongly recommend providers submit prior authorization requests via the iExchange web portal. Telephonic training is available to assist your team so they can be prepared for future submissions of cases.

Benefits of iExchange

- Direct electronic submission
- Immediate feedback from WPS
- Assignment of a Case ID number
- Monitoring the status of the request
- Communication with WPS through iExchange
- Alerts when the case is updated
- Ability to electronically attach medical records to iExchange
- Printable requests/approvals for the provider

By giving providers access to the iExchange web portal, we hope to improve communication and collaboration with our provider community, recognizing that your patients are our members.

Enroll in iExchange

To begin using the iExchange web portal, please request access using one of the following methods:

- Register on our web page at Register for iExchange®
- Email iExchange@wpsic.com
- Call 800-333-5003 and ask to speak with an iExchange representative

To learn more about iExchange and request passwords or training, visit the WPS iExchange Web Portal at wpsic.com/iexchange/index.shtml.

Magellan Healthcare Web Portal for Rehabilitative Therapy Authorizations

The Magellan Healthcare web portal is accessible on our iExchange® Overview page. The portal allows clinical staff to submit electronic authorization requests for professional and outpatient rehabilitative services. WPS encourages rehabilitative therapy providers to use the web portal for all authorization requests.

Benefits of Magellan Healthcare Portal

- Increased rate of auto-approval
- Email alerts on case updates (if an email address is provided)
- Online status monitoring
- Immediate Magellan Healthcare feedback

- Medical records submission (if records are requested by Magellan Healthcare)
- Online printing of requests and letters
- Clinical resources for PT, OT, and ST providers

Using the Magellan Healthcare Portal

If you already have an account with Magellan Healthcare, you can use the same account to request services for WPS members. If you do not have an existing account, please contact Magellan Healthcare Provider Services at 800-432-3640, option 3, for assistance.

INTEGRATED CARE MANAGEMENT (ICM)

Overview

The Integrated Care Management (ICM) Program is designed to monitor the appropriateness of all medically necessary and covered services for pre-service care, concurrent review, and post-service care delivered to WPS members.

Health care providers contracted with WPS and the WPS clinical team collaborated to develop the ICM Program. The strategy of our ICM Program is to promote optimal practice while accounting for the structure of local delivery systems. All components of the program comply with federal and state regulations.

The program is designed to make utilization decisions affecting the health care of members in a fair, impartial, and consistent manner. The WPS ICM Program provides a systematic method to manage member utilization of services. The management of services focuses on the ongoing monitoring and evaluation of medical necessity, the appropriateness of level of care, the place of service, and availability of resources and benefits, while ensuring confidentiality of personal health information for all members. The main goals of the ICM Program are to ensure all members receive “the right care at the right time in the right place” and to reduce the amount of low-value and unproven care, thereby being a wise steward of limited resources.

The WPS Medical Affairs Department developed and maintains the Integrated Care Management Program. The WPS Chief Medical Officer (CMO) is responsible for overseeing key aspects of the program, such as:

- Committees and programs, including the Medical Policy Committee, the Quality Program, and the Credentialing Committee
- The Medical Directors and Physician Advisors who render the medical necessity determinations and provide peer-to-peer consultations with external physicians who provide care to our members
- Policies that govern prior authorization, concurrent, and post-service review, as well as the case management programs
- Medical necessity denial decisions, as well as those related to the determination of whether a service is experimental, investigational, or unproven

The WPS Medical Directors consult with appropriate board-certified specialists if the medical necessity reviews require expertise beyond their scope of expertise.

The WPS Medical Affairs Department is staffed by RN Integrated Care Managers, Nurse Integrated Care Reviewers, Pharmacists, Behavioral Health Care Specialists, Physician Medical Directors, and other non-licensed support personnel who are available to assist our network physicians for ICM issues and questions.

Objectives

The main goal of the Integrated Care Management (ICM) Program is to oversee the quality of relevant care while promoting appropriate utilization of medical services and Plan resources.

The objectives of the ICM Program are to:

1. Provide a structured process to continually monitor and evaluate the delivery of health care services to our members by:
    - Establishing system-wide health management processes across the continuum of care.
    - Providing access to high-quality, medically necessary health care services in the most appropriate and cost-effective setting.
    - Ensuring effective and efficient utilization of health care services and benefits by appropriate allocation of resources and services in the inpatient, outpatient, and rehabilitative settings.
    - Ensuring health care services are coordinated, timely, medically effective, and efficient.
    - Establishing a process for provider feedback regarding utilization and the ICM program.
    - Periodic auditing of denial decision timeliness and consistency.
    - Conducting inter-rater reliability audits of all RN Integrated Care Managers and the Medical Directors.
2. Improve clinical outcomes via:
    - System-wide collaboration to identify, develop, and implement clinical practice guidelines and programs that address key health care needs of the members.
    - Implementation of clear, consistent ICM requirements and key success indicators.
    - Facilitation and coordination of health care services for members in need of acute and chronic health care services and facilitation of communication with providers to support appropriate utilization of health care benefits.
    - Implementation of behavioral health care management processes.
    - Documentation and evaluation of patterns of resource utilization, including under- and over-utilization of services and implementation of actions for improvement as appropriate.
    - Collaboration with the Quality Improvement (QI) Department, Medical Director, the Director, and Manager of Integrated Care Management to assess and implement actions to improve continuity and coordination of care.

- Providing the QI area with data and support to identify areas for improvement, establish priorities, and assist in interventions for service, adverse events, and quality-of-care concerns.

3. Improve practitioner and member satisfaction by:
   - Assessing practitioner and member satisfaction with ICM policies and procedures.
   - Promoting appropriate utilization of WPS resources through efficiency of service.
   - Educating providers and members regarding ICM goals, regulatory standards, criteria used for review, and processes for providing cost-effective and high-quality care.
   - Incorporating WPS providers' input into the ongoing development and implementation of ICM program components.

4. Meet or exceed established quality standards by:
   - Meeting all appropriate regulatory requirements.
   - Ensuring consistency in ICM decision-making.
   - Rendering timely ICM determinations and issue timely notifications of decisions.

The scope of the ICM Program consists of the following components:

- Affirmative statement on incentives
- Behavioral health care management program
- Chiropractic care management program
- Complex case management program
- Concurrent review decisions
- Disease management programs
- Emergency services
- Health care informatics
- Pharmacy and specialty drug management program
- Post-service review decisions
- Prior authorization (PA) determination of medical services
- Reporting
- Technology assessment
- Therapy management program

Resources and Tools

The following resources and tools support the ICM Program:

Clinical Experts
In addition to the Medical Directors, ICM has access to clinical experts through the WPS Practitioner Panel, many of whom are Board Certified and participate on various committees at WPS. WPS also purchases a variety of expert services through external vendors. Examples of expert vendors used are:

- ALLMED
- Medical Review Institute of America
- National Medical Reviews, Inc.

Clinical Practice Guidelines
ICM staff have access to clinical practice guidelines from multiple professional organizations, which are also published on the WPS website for providers. Some sources for clinical practice guidelines used are referenced below. For a complete list, see the Medical Policies section of our website.

- American Academy of Family Practice (AAFP)
- American Academy of Pediatrics (AAP)
- American College of Cardiology (ACC)/American Heart Association (AHA)
- American College of Physicians (ACP)
- Institute for Clinical Systems Improvement Health Care Guideline (ICSI)
- National Institute for Health and Care Excellence
- National Institute of Health (NIH)
- U.S Preventive Services Task Force (USPSTF)

Criteria (as defined in Certificate of Coverage):

Criteria are applied consistently to medical necessity decisions, and in a manner that is responsive to individual member needs and the characteristics of the local delivery system. The criteria are used as a guideline and not intended to replace appropriate clinical judgment. The ICM decision-maker considers the member's medical and psychological status (age, comorbidities, complications, and progress of treatment); home situation and supports; community supports; provider and practitioner network; and availability of services. Certain categories of services may not be reviewed for medical necessity if screening reveals that they represent clear certificate or benefit exclusions.

WPS uses the following criteria, which is not an all-inclusive list:

- Cochrane Library
- Council on Chiropractic Guidelines and Practice Parameters (CCGPP)
- Hayes
- Information from appropriate government regulatory bodies (e.g., Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), U.S. Department of Health & Human Services
- MCG Care Guidelines
- Medical Affairs Medical Policy
- National Comprehensive Cancer Network (NCCN)
- National Guidelines Clearinghouse
- National Imaging Associates Clinical Guidelines
- National Institutes of Health
- National Library of Medicine Search
- Pubmed (Medicine)

- Specialty Society guidelines and standards (e.g., The American Academy of Pediatrics, American College of Physicians, The American Cancer Society, The American Medical Association)
- United States Preventive Services Task Force: USPSTF (for preventive services only)
- UpToDate—consensus-based vendor resource

Note: MCG, Hayes, and all other guidelines are used in conjunction with the independent professional medical judgment of a qualified health care provider.

Integrated Care Management Definitions

Many of the definitions below are derived from WPS member certificates, which may vary depending on the type of plan the member or the employer purchased.

Concurrent Review: Utilization management conducted during a patient's hospital stay or course of treatment (including outpatient procedures and services). Sometimes referred to as "continued stay review."

Cosmetic Treatment: Any health care services used solely to improve the patient's physical appearance or self-esteem. Treatment of a condition due to psychological symptoms without a functional impairment or threat to health is considered cosmetic treatment.

Evidence-Based: Recommendations based on valid scientific outcomes research, preferably research that is published in peer-reviewed scientific journals. Evidence-based information can be used to develop protocols, pathways, standards of care, or clinical practice guidelines and related educational materials.

Experimental or Investigational/Unproven: As determined by our Corporate Medical Director, any health care service or facility that meets at least one of the following criteria:

1. It is not currently recognized as accepted medical practice
2. It was not recognized as accepted medical practice at the time the charges were incurred
3. It has not been approved by the United States Food and Drug Administration (FDA) upon completion of Phase III clinical investigation
4. It is being used in a way that is not approved by the FDA or listed in the FDA-approved labeling (i.e., off-label use), except for off-label uses that are accepted medical practice
5. It has not successfully completed all phases of clinical trials, unless required by law
6. It is based upon, or similar to, a treatment protocol used in ongoing clinical trials
7. Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that it is safe and effective for the member's condition
8. There is not enough scientific evidence to demonstrate or make a convincing argument that (a) it can measure or alter the sought-after changes to illness or injury or (b) such measurement or alteration will

affect the health outcome; or support conclusions concerning the effect of the drug, device, procedure, service, or treatment on health outcomes
9. It is associated with a Category III CPT code developed by the American Medical Association

The above list is not all-inclusive.

Integrated Care Management: A general term encompassing activities such as case management, disease management, utilization management, and the clinical aspects of quality management.

Medical Emergency: A medical condition that manifests by acute and abnormal signs and symptoms of such severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child
2. Serious impairment to the person's bodily functions
3. Serious dysfunction of one or more of the person's body organs or parts

Medically Necessary: A health care service directly provided to the member by a health care provider that is required to identify or treat illness or injury and which is determined by WPS to be:

1. Consistent with, and appropriate for, the diagnosis or treatment of the member's illness or injury
2. Commonly and customarily recognized and generally accepted by the medical profession in the United States as appropriate and standard care for the condition being evaluated or treated
3. Substantiated by the clinical documentation
4. The most appropriate and cost-effective level of care that can safely be provided to the member (appropriate and cost-effective does not necessarily mean the least expensive)
5. Proven to be useful or likely to be successful, yield additional information, or improve clinical outcome
6. Not primarily for the convenience or preference of the covered person, his/her family, or any health care provider

A health care service or facility may be considered not medically necessary even if the health care provider performed, prescribed, recommended, ordered, or approved the service, or if the service is the only available procedure or treatment for the member's condition.

Post-Service Request: Also referred to as a retrospective request. This is a request for coverage of medical care or services that were already rendered to the member.

Prior Authorization: Also referred to as prospective or pre-service review. This is the request for coverage of medical care or services that WPS must approve, in whole or in part, prior to the member obtaining that medical service.

Reconstructive Surgery: Surgery performed on abnormal structures of the body caused by (a) congenital defects; (2) developmental abnormalities; (3) trauma; (4) infection; (5) tumors; or (6) disease. The presence of a psychological condition alone will not entitle a member to coverage for plastic or reconstructive surgery.

Urgent Request: A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Behavioral Health Care Definitions

Day Treatment Programs: Nonresidential programs for the treatment of substance use disorders and nervous or mental disorders that are operated by certified inpatient and outpatient Alcohol and Other Drug Abuse (AODA) facilities that provide case management, counseling, medical care, and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week; also known as partial hospitalization.

Inpatient Hospital Services: Services for the treatment of nervous or mental disorders or substance use disorders that are directly provided to a member who is a bed patient in a hospital.

Outpatient Services: Nonresidential services for the treatment of nervous or mental disorders or substance use disorders directly provided to a member and, if for the purpose of enhancing the member's treatment, a collateral by any of the following:

- A program in an outpatient treatment facility, if both the program and facility are approved by the Department of Health Services and established and maintained according to rules promulgated under Wisconsin Statutes (Wis. Stat.) Section 51.42 (7)(b) and 51.04
- A licensed physician who completed a residency in psychiatry, in an outpatient treatment facility or the physician's office
- A psychologist
- A licensed mental health professional practicing within the scope of his/her license under Wis. Stat. Chapter 457 and applicable rules
- A health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, or substance use disorders within the scope of that license

Residential Treatment Programs: Therapeutic programs for the treatment of nervous or mental disorders and substance use disorders, including therapeutic communities and transitional facilities.

Transitional Treatment: Services for the treatment of nervous or mental disorders and substance use disorders that are directly provided to the member in a less restrictive manner than inpatient hospital services, but in a more intensive manner than outpatient services, if both the program and the facility are approved by the Department of Health Services as defined in the Wisconsin Administrative Code Section INS 3.37.

Transitional treatment includes any of the following health care services if provided by a health care provider certified by the Department of Health Services:

- Mental health services for covered adults, adolescents, or children in a day treatment program
- Services for members with chronic mental illness provided through a community support program
- Residential treatment programs for treatment of a member's nervous or mental disorders and/or substance use disorders
- Services for substance use disorders provided in a day treatment program
- Intensive outpatient programs for substance use disorders and for treatment of nervous or mental disorders
- Coordinated emergency mental health services that are provided by a licensed mental health professional for members experiencing a mental health crisis or in a situation likely to turn into a mental health crisis if support is not provided

The criteria WPS uses to evaluate a transitional treatment program or service to determine whether it is medically necessary and covered under the policy include, but are not limited to, whether:

- The transitional treatment is certified by the Department of Health Services
- The transitional treatment meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations
- The specific diagnosis is consistent with the symptoms
- The treatment is standard medical practice and appropriate for the specific diagnosis
- The treatment plan is focused for the specific diagnosis
- The multidisciplinary team providing the transitional treatment is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider's program is located or the service is provided

WPS will need the following information from the health care provider to determine the medical necessity of transitional treatment:

- A summary of the development of the member's illness and previous treatment
- A well-defined treatment plan listing treatment objectives, goals, and duration of the care provided under the transitional treatment program
- A list of credentials for the staff who participated in the transitional treatment program or service, unless the program or service is certified by the Department of Health Services

Prior Authorization

The Integrated Care Management (ICM) Program requires prior authorization (PA) for all services referred to inpatient facilities (including rehabilitation and skilled nursing facilities), tertiary care specialist/facility and providers, and for other select services. We review these services for member eligibility, benefit coverage, medical necessity, and/or coordination of care/services. For our most current list of services requiring prior authorization, please see our Prior Authorization List.

Utilization management (UM) decision-making is based only on appropriateness of care and service and existence of coverage. WPS does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Review Process

- Providers submit requests via fax, phone, mail, or online through iExchange.
- The ICM team obtains all data and relevant information, including, but not limited to, medical records and communications with practitioners or other consultants.
- We use utilization management (UM) criteria to review relevant information as described in the resources/tools section.
- We review inpatient facility care, such as observation, acute, rehabilitation, and/or skilled nursing care, prior to or within 24 business hours of admission, then concurrently according to accepted criteria and guidelines.
- We provide non-urgent PA *approval* determinations to practitioners and members via verbal, written, or electronic notification within 15 calendar days of the request. We provide non-urgent PA *denial* determinations within 15 calendar days of the request via written or electronic notification.
- We provide urgent PA *approval* determinations to practitioners and members via verbal, written, or electronic notification within 72 hours of the request. We provide urgent *denial* determinations within 72 hours of the request via verbal, written, or electronic notification.
- We send PA approval determination letters for select services and all denials to the member, the rendering practitioner, and the facility, if appropriate.
- The Medical Director reviews and renders a determination for all potential medical necessity denials.

All written denial determination notifications include:

- The specific reason for the denial.
- A reference to the benefit provision, guideline, protocol, or other similar criterion used for the denial decision.
- An offer to provide, upon request, a copy of the actual benefit provision, guideline, diagnosis/treatment codes, protocol, or other similar criterion on which the denial decision was based.
- A description of appeal/grievance rights, including the right to

submit written comments, documentation, or other information relevant to the appeal/grievance.
- An explanation of the appeal/grievance process, including the right to member representation, and time frames for deciding appeals/grievances.
- A description of the expedited appeal/grievance process for urgent prior authorization or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care and ongoing treatment.
- Notice of the external review process, if applicable.
- Contact information for language assistance.

Below is a list of health care services that require prior authorization. Our most current list is available on our website at WPS Prior Authorization List.

- Alternative communications device/speech-generating device or digitized speech
- Bone-anchored hearing aids (BAHA)
- Bariatric surgical services
- Biofeedback
- Behavioral health care services: inpatient and residential
- Bone growth stimulators
- Botulinum toxin injection
- CPAP and BiPAP machines
- Clinical trials
- Cochlear implants
- Cosmetic and plastic surgery procedures
- Cranial orthotics
- Deep brain stimulation (DBS)
- Durable medical equipment with a purchase price greater than $1,000 or rental greater than $750 per month
- Genetic testing
- Home infusion services
- Hyperbaric oxygen therapy
- Intensity modulated radiation therapy (IMRT)
- Immune Globulin (IVIG)
- Inpatient Admissions: Planned (elective/scheduled) to include skilled nursing facility (SNF), long-term acute care (LTAC) facility, and inpatient hospice facility
- Intraoperative neuropsychological monitoring
- Neuropsychological testing
- Neurostimulation
- New technology: Medical, surgical, or biomedical services that might be considered experimental, investigational, or unproven
- Pain-management procedures as follows:
    - Automated percutaneous lumbar diskectomy
    - Epidural steroid injections

    - Facet joint injections (includes facet, MBB, zygapophysical joint, paravertebral facet joint, and dorsal/posterior ramus injections)
- Pediatric vision and orthoptic/pleoptic training
- Physical, occupational, and speech therapy (submit to Magellan Healthcare)
- Prosthetics
- Proton beam radiotherapy
- Sleep study evaluation and treatment of sleep disorders
- Spinal surgery
- Stereotactic radiosurgery/radiotherapy
- Therapeutic contact lens
- Total ankle arthroplasty
- Total shoulder arthroplasty
- Transplants
- Transport of patients: non-emergency (MediVan, ground or air ambulance)

Concurrent Review

Concurrent review decisions are reviews for the extension of previously approved, ongoing care. This includes the review of inpatient care as it is occurring or ongoing ambulatory care.

Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care and supports the health care provider in coordinating a member's care across the continuum of health care services.

Concurrent Review Process

- Integrated Care Management (ICM) team completes inpatient concurrent review telephonically or via fax.
- ICM team obtains all data and relevant information, including, but not limited to, medical records and communications with practitioners or other consultants.
- We use UM criteria to review relevant information as described in the resources/tools section.
- We review inpatient facility care, such as acute, rehabilitation, and/or skilled nursing care concurrently for the duration of the stay, according to accepted UM criteria and guidelines.
- We provide urgent *approval* determinations to practitioners via verbal, written, or electronic notification communicated through the facility case managers or discharge planners within 24 hours of receipt of the request. We provide urgent concurrent denial determinations within 24 hours of the receipt of the request verbally or electronically followed by written notification.
- The Medical Director reviews and renders a determination for all potential medical necessity denials.

POST-SERVICE DETERMINATION

Post-Service Process

- Post-service decisions are determinations of medical necessity and/or appropriate level of care when the member already received services (e.g., retrospective review).
- We communicate post-service determinations electronically or in writing to the practitioner and member within 30 calendar days of the request.
- We use UM criteria to review relevant information and data as described in the resources/tools section of this manual.
- The Medical Director reviews and renders a determination for all potential medical necessity or inappropriate level of care denials.

PEER-TO-PEER REVIEW

We offer a peer-to-peer discussion with a WPS physician reviewer or Medical Director to the ordering provider for the denial of services that are determined to be not medically necessary or experimental or investigational. It is another opportunity to provide additional information relevant to the denial decision.

Prior to requesting a peer-to-peer review, please review our medical policies and MCG guidelines related to the service or issue to be discussed. These guidelines and policies may help provide insight on what WPS uses as criteria for decisions on a case review.

The discussion will be with the requesting provider and a WPS physician Medical Director or a contracted physician reviewer. It may involve a chiropractor, rehabilitation therapist, or a pharmacist, when appropriate.

If the decision for denial for services is upheld, the next step is a grievance, which must be requested by the member according to the directions provided in the denial letter. This option and process is discussed and offered during a peer-to-peer review if the denial decision is upheld.

BEHAVIORAL HEALTH CARE

Benefits

WPS will pay benefits for charges for covered expenses the member incurs for inpatient hospital services, outpatient services, and transitional treatment each calendar year based on the member's benefits.

No benefits are payable for charges for outpatient services provided in a family/group setting if the member is not the provider-identified patient receiving the benefit of the services.

For applicable benefit plans, WPS follows the Mental Health Parity and Addiction Equity Act when reviewing services for behavioral health care and substance use disorders.

The Behavioral Health care program follows the same review process in the previous sections for prior authorization, concurrent review, and post service review.

Outpatient Behavioral Health Treatment Plans

To submit a request for outpatient treatment, please fill out the appropriate form below and fax to 608-226-4777.

- Prior authorization Request/Psychological and Neuropsychological Testing
- Outpatient Behavioral Health Care Treatment Request Form

Autism Treatment Plans

To submit a request for autism services, please fill out the applicable form below and fax to 608-226-4777.

- Professional Staff Update Notification
- Autism Spectrum Progress Report form

REFERRALS

Under applicable WPS plans, referrals may be required when a preferred provider sends the member to a non-preferred specialty provider or facility for health care services to treat a covered illness or injury.

Please contact Member Services at the toll-free number listed on the back of the member's ID card to determine whether a referral is needed. If so, WPS requires that you complete a Referral Authorization Request Form prior to services being rendered.

The referral must be:

1. Requested by a preferred physician
2. Received by WPS in writing or by telephone prior to rendering of the health care services
3. For health care services not otherwise available from a preferred provider
4. Approved in writing by WPS
5. Valid for the period of time specified by WPS

PHARMACY MANAGEMENT

WPS offers a comprehensive prescription drug program, including a suitable array of products, to allow practitioners to appropriately manage their patients.

The WPS Director of Pharmacy and Chief Medical Officer provide the program leadership.

The WPS Pharmacy Program is overseen by the Quality Improvement Committee and administered by Express Scripts®.

The Pharmacy Management Program is reviewed at least annually and updated as needed. Changes to the program are communicated to practitioners via direct mail, email, and/or the internet. WPS contracts with Express Scripts to process pharmacy claims. Express Scripts is also our exclusive provider of home delivery pharmacy services.

Note: Not all members receive their drug benefits through WPS. Please verify drug benefits by checking the member's ID card.

Formulary

WPS uses a formulary, called the **WPS Preferred Drugs Guide**, which is designed and maintained by Express Scripts. It can be accessed online at wpsic.com: click on the **Providers** tab and then select the **Pharmacy/Rx** link to access the appropriate section of our website. A formulary is a list of drugs that can be used by practitioners to identify drugs that offer the greatest overall value. It does not guarantee coverage and should only be used as a guide.

Tiered Drug Benefits—Member Responsibility Determination

The most common pharmacy benefit is tiered. The copay/coinsurance levels vary based upon the tier of the drug prescribed.

1. Generic drugs on the formulary carry the lowest responsibility (first tier)
2. Brand-name drugs on the formulary are the middle responsibility (second tier)
3. Brand-name drugs ***not*** on the formulary carry the highest responsibility (third tier)
4. Some plans have a fourth tier that is unique for specialty drugs; in this situation, specialty drugs, whether brand or generic, formulary or non-formulary, are subject to specific cost sharing

Note: Qualified high-deductible health plans have a combined medical and pharmacy benefit that does not incorporate a tiered benefit.

Covered Drugs

In general, the prescription drug benefit covers FDA-approved drugs that, by law, require a prescription from a licensed practitioner, and, by certificate, are medically necessary.

Insulin and disposable diabetic supplies that, by law, may not require a prescription, are also eligible for coverage. However, to be eligible for coverage, WPS requires they must be medically necessary and a prescription must be written.

Commonly Excluded Drugs

- Drugs to treat toenail or fingernail fungus
- Drugs used for fertility or whose primary use is fertility

- Compounded medications that do not contain at least one legend ingredient
- Non-legend drugs (those available without a prescription)
- Experimental, investigational, or unproven drugs
- Replacement medications resulting from loss, theft, or damage
- Any drug used for weight control
- Any drug used for cosmetic purposes or whose use is not medically necessary
- A covered drug related to a non-covered medical encounter
- Anabolic steroids, unless prior authorization is obtained
- Medical supplies not specified as covered in the member certificate
- Injectable medications, except as determined by WPS or its designee
- Any drug without the proper plan authorization as outlined in the certificate

Member Given Generic Drug When Brand-Name Drug is Prescribed

When an FDA-approved generic version of a brand-name drug is available, WPS may limit coverage to the generic form of a drug. The active ingredient(s) in a generic drug is chemically identical to its brand-name counterpart. Pharmacists will dispense the generic medication in this situation. If the member requests the brand, the member will be responsible for the appropriate copay/deductible/coinsurance plus the difference in cost between the brand and the generic.

Drug Therapy—Site of Care Program

Most WPS member benefit plans contain language that permits us to direct care to the most cost-effective place of service that is clinically appropriate for the member's situation. Examples of this include having a patient self-administer a drug instead of receiving it in the provider's office. It could also mean using home care services in place of an infusion center or outpatient hospital setting.

DRUG PRIOR AUTHORIZATION

SPECIALITY DRUGS

WPS has engaged Diplomat to assist with specialty drug management. WPS requires an approved prior authorization for most specialty drugs. On behalf of WPS, Diplomat reviews specialty drug requests for all service settings (e.g., outpatient, office, home) except inpatient. Treatments subject to this program include, but are not limited to, specialty drugs for cancer, multiple sclerosis, and inflammatory conditions.

Coverage policies for specialty drugs can be found on our website, wpsic.com, under Medical Policies.

Specialty drugs dispensed without proper authorization will not be reimbursed, and the member cannot be balance billed.

DRUG PRIOR AUTHORIZATION

The list of drugs requiring prior authorization can be viewed online at Drug Prior Authorization List. The list outlines whether Diplomat, Express Scripts, or WPS perform the review for the drug in question.

In each situation, when a provider is seeking a review, please call the correct company at the phone number below. Phone calls are preferred to efficiently identify the necessary clinical information to complete the review.

- Diplomat (Specialty Drugs) **888-515-1357**
- Express Scripts (Traditional Drugs) **800-753-2851**
- WPS (Drugs most policies do not cover, e.g., fertility) **800-333-5003**

When calling, please have available the patient's ID number (from his/her card), date of birth, and access to the medical record. You will be asked questions related to diagnosis, medication history, and other relevant clinical information. The provider's office should contact the member regarding the decision.

COMPLEX CASE MANAGEMENT (CCM) PROGRAM

Complex Case Management is the coordination of care and services provided to members who experienced a critical event or have a diagnosis that requires the extensive use of resources and assistance in navigating the system to receive the appropriate delivery of care and services. The CCM program is an opt-in program. This allows all eligible members to choose their participation in the program.

Evidence used to develop the Complex Case Management Program: WPS developed the CCM Program based upon MCG Health guidelines and/or nationally recognized evidence-based clinical guidelines.

Criteria to identify members who are eligible for the program: Currently WPS uses the following data sources to identify members for case management:

- **Claims or encounter data**: These reports identify transplant, high-dollar, trauma, and chronic illness cases that result in high utilization.
- **Hospital discharge data:** Hospital prior authorization and concurrent review for all members allow the opportunity to evaluate the need for coordination of services for members with complex conditions and helps them access needed resources.
- **Discharge planner referrals:** The nurse integrated care manager and hospital discharge planner evaluate the member's discharge needs for continued services and determine if there is a need for case management intervention.
- **Pharmacy data**: This data identifies categories such as high-dollar expenditure, therapeutic drugs, new to therapy, and high pharmacy utilization.

- **Data obtained through utilization management:** The prior authorization process assists nurse integrated care managers in identifying members with complex conditions and in evaluating the need for assistance with coordination of care.
- **Data supplied by purchasers, if applicable**.

Services offered to members
During the CCM process, the case manager:

- Performs a detailed assessment and clinical history of the member's health status specific to identified health conditions and likely co-morbidities.
- Reviews available certificate benefits and directs the member to in-network providers if applicable.
- Facilitates referrals to resources, such as community resources, Employee Assistance Programs (EAP), Disease Management, etc., as well as follows up on whether the member acted on these referrals as needed.
- Interacts with providers to include the member's PCP, specialist, DME/infusion company, etc., based on the member's current needs.
- Develops and communicates a member self-management plan with the identification of goals and any barriers to meet those goals. The case manager creates a communication schedule with the member during the CCM process.

Defined program goals
The purpose of the WPS CCM Program is to assist members to regain optimum health or improved functional capability in the most appropriate and cost-effective care setting to meet their needs. The following goals will ultimately assist the organization to reduce costs and add value to members:

- Members will be able to obtain access to high-quality care and appropriate services through coordination of care to meet their health care needs.
- Case managers will provide support and education to members in order to reach their maximum achievable health potential and independence.
- The member or caregiver will be self-empowered to know what steps to take if a medical condition changes.

Disease Management
The Disease Management Program identifies members with chronic conditions, such as asthma and hypertension, to target their interactions with the health plan to improve health outcomes. The objective is to provide innovative and effective support to members and providers in managing these conditions.

The scope of the Disease Management Program consists of the following components:

- Members have regular interaction with the Disease Management case manager, who teaches them about their conditions and how to stay well.
- The case manager sends relevant health education materials with additional wellness topics to members.
- The case manager assists to bridge any communication gaps that may occur

between providers and members.
- The case manager develops timely alerts to providers regarding changes in members' conditions.
- The case manager obtains current information to manage members effectively before an emergent event occurs.

Members have access to our 24/7 online tools and resources on our website: wpsic.com. Those who qualify for interventions also receive:

- Highly trained case managers to answer questions and provide guidance
- Care plan follow-up and reminders
- Medication management
- Referrals to wellness coaching, if needed
- Self-management tools
- Screening for depression

For referrals and additional disease management program information or questions, please call the Medical Affairs Department at 800-333-5003.

PEDIATRIC VISION MANAGEMENT

The pediatric vision care benefit is offered on limited plans to members who are under age 19. Please contact Member Services for specific coverage information and prior authorization guidelines.

WPS contracted with Classic Optical Laboratories Inc. to provide covered eyeglasses and eyeglass component parts to members who have the pediatric vision hardware benefit.

A selection of frames can be viewed and purchased for display at ClassicOptical.com. Through the Classic Optical Laboratories website, providers can place and track orders for covered eyeglasses, verify frame availability and changes to selection. When ordering online, Classic Optical's *smart* ordering form will only allow covered materials and frames to be ordered.

To access these online options, providers are required to have a username and password that can be requested in one of two ways:

- Online: complete and submit a request form online. To access the request form online, click the **Contact Us** link at classicoptical.com.
- Phone: call Classic Optical Laboratories at 888-522-2020 during regular business hours (8 a.m.–6 p.m. CT, Monday through Friday).

Eyeglasses and eyeglass component parts not provided by the WPS contracted vendor will not be reimbursed by WPS without prior authorization. Providers cannot bill the member without prior written acknowledgement and consent of the member.

EMERGENCY/URGENT CARE

Emergency Medical Care is defined as a health care service provided by a health care provider to treat a medical emergency.

A medical emergency is a medical condition that manifests itself by acute and abnormal signs and symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
2. Serious impairment to the person's bodily functions; or
3. Serious dysfunction of one or more of the person's body organs or parts.

WPS provides coverage for emergency services provided to a member by network or non-network providers, subject to the terms of the member's benefit plan.

Emergency Care Guidelines
Emergency medical care does not include non-emergency, urgent care, routine health care, dental, or maintenance treatment, services and supplies, and/or routine medical exams.

Emergency hospital admissions are not subject to prior authorization requirements stated in the member's benefit plan. However, if a member is admitted on an emergency basis, the provider or the member should notify us within two business days of the admission date.

A copayment may apply to a member's use of a hospital emergency room. The copayment amount applies to each member for each visit to the hospital emergency room or any other facility charge as an extension of the hospital emergency room, including urgent care rooms.

After any applicable hospital emergency room copayment amount is applied, WPS will apply benefits as stated in the member's benefit plan for the emergency room fee billed by the hospital for use of the hospital emergency room. This does not include miscellaneous hospital expenses and other health care services provided during the visit to the hospital emergency room.

If a member receives health care services from an urgent care facility within a hospital, applicable copayments as stated in the member's benefit plan may apply.

Hospital emergency room copayment may be waived for emergency room visits if the member is admitted as a resident patient to the hospital directly from the hospital emergency room.

Urgent Care is defined as care received for an illness or injury with symptoms of sudden or recent onset that require medical care the same day.

QUALITY IMPROVEMENT PROGRAM

Mission, Vision, and Commitment to Our Members

In today's health care environment, effective medical management requires rigorous data analysis. We've invested in a powerful collaborative care management platform that streamlines data collection, applies clinical rules, automates workflows, and electronically connects patients with their providers. This system allows us to more intelligently administer medical management services, which improves health care quality and reduces costs.

Our Quality Improvement (QI) Program drives organizational improvement for excellence through efficiencies, increasing the competitive advantage, building trust and recognition in the community to improve the health status and satisfaction of our members. We commit to our members and providers our dedication to professional standards, evidence-based medicine and ethical practice behavior. On an ongoing basis, we integrate clinical advances, implement innovations and measure health outcomes of our members.

We continually refine our health care team and member know-how to:

- Conduct and support research on the effectiveness of treatments
- Ensure that clinicians, patients, and policymakers have the information they need to enhance the quality of care
- Identify any gaps in access to or use of health care

Program Structure

The QI Committee provides structure for promoting and achieving excellence in all areas and at all levels of the organization. The QI Committee will have oversight for the structure and resources that are to be reviewed throughout the calendar year.

Objectives:

- Monitor the QI Program quarterly to assess progress and resource allocation
- Develop, review, and report on the annual QI Program work plan
- Assess and evaluate effectiveness of health plan activities
- Monitor Quality of Care for all members, including responding and facilitating resolution to member complaints
- Assess and evaluate delegated activities
- Monitor and align accreditation with process improvement teams

The QI Committee relies on industry standards set by regulators or accrediting organizations and “best practices” to guide them throughout the year. The use of data collection and analysis is critical to identifying populations, problem-solving and process improvement. Information about the QI Program is available for members and providers upon request.

Purpose of the Quality Improvement (QI) Program

The QI Program is the framework for a formal process to assess and monitor our performance through a systematic approach of monitoring and evaluating the quality and the effectiveness of care for our members. This approach enables us to focus on issues of appropriateness, efficiency, safety, as well as health outcomes and the satisfaction of our members and their providers. This is achieved by continuous monitoring of our performance according to, or in comparison with, objective, measurable performance standards. The QI Program promotes accountability and ensures identification and evaluation of issues that impact our ability to better our performance and improve health care and administrative services provided to our customers.

Program Goals and Key Objectives

The primary goal is to integrate all existing quality activities into one comprehensive program for monitoring activity, share ideas over multiple programs, focusing resources, and promoting programs. The QI Program goals are achieved through the integration and coordination of clinical and non-clinical services guided by these specific goals and key objectives. The following goals are the areas of focus and priority. The objectives include the main plan-wide initiatives that will be undertaken to ensure achievement of the goal. Our guiding principle is to provide services with the following characteristics of evidence based data driven decisions for the safety, and welfare of our members.

Program’s Functional Areas and Responsibilities

The QI Program includes all aspects of services provided by health plan practitioners, providers and staff. The plan arranges for the provision of comprehensive health care delivery through a network of primary care and specialty practitioners, behavioral health practitioners and clinicians, ancillary care provider hospitals, and other health facilities. The program’s scope, which is determined following an annual analysis of the population and its demo-graphic and clinical characteristics, includes the monitoring and evaluation of high-volume, high-risk clinical and service issues. Performance goals and thresholds are established for all measures, and are trended over time.

The QI Program provides an organizational process that supports ongoing improvement of care and service, and improvement of the health of its members. The program is responsive to the changing needs of the health care environment and the standards established by our local medical community, national regulatory bodies, and national accrediting bodies.

Reporting Relationships of QI Department Staff and the QI Committee

- **Chief Medical Officer (CMO):** The CMO is responsible for the oversight of Medical Affairs, including the Quality Improvement Committee. The CMO is responsible for ensuring implementation of all aspects of the Medical Management Programs. The CMO reports to the Chief Executive Office and reports to the Executive Staff on quality issues and updates as outlined in the QI Program Description.

- **Medical Director—Network and Quality:** The Medical Director or Designee is responsible for ensuring the implementation of all aspects of the Quality Improvement Program, as delegated by the CMO. The Medical Director chairs the Quality Improvement, Credentialing, and Medical Policy Committees. The Medical Director reports directly to the Chief Medical Officer.

- **Director of Quality and System Support:** The Director, Quality and System Support is responsible for coordinating the operational components of the QI Program under the direction of the Chief Medical Officer and Medical Director. This position reports directly to the Medical Affairs Senior Director.

- **Manager of Medical Management Quality and Operations:** The Manager of Medical Management Quality and Operations is responsible for coordinating the operational components of the Medical Management Program and the Quality Improvement Program. This position reports to the Director, Quality and System Support.

- **Quality Improvement Specialists:** The QI Specialists are responsible for assisting with the operational components of the QI Program. This includes project coordination of Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems surveys (CAHPS) AHPS, and other quality initiatives and state and federal reporting requirements. The Quality Improvement Specialists report to the Manager of Medical Management Quality and Operations.

- **Health Care Informatics Manager:** The Health Care Informatics Manager is responsible for having the Health Care Informatics Team generate reports and statistical analysis to assist with HEDIS/CAHPS and other quality initiatives. This position reports to the Director of Quality and System Support.

- **Behavioral Health Care Practitioners:** The Behavioral Health Care Practitioners are involved in the behavioral health care aspects of the Quality Improvement Program. They serve on the QI, Medical Policy, Credentialing, and other ad hoc committees and teams.

QI Committee Organizational Structure

The committee structure, line of authority, and responsibility for the QI Committee is described as follows. The Chief Medical Officer oversees the QI

Committee. The QI Committee oversees the Credentialing Committee and Medical Policy Committee. The Health Insurance Grievance and Appeals Committee is under the oversight of WPS Operations, for which Medical Affairs has medical oversight and one voting committee member.

Each committee is required to contemporaneously record meeting minutes. The exception to this is the Grievance Committees due to the meeting content being primarily protected health information. Database information and individual files are maintained. All other meeting minutes are dated and signed by the committee chair when approved. Summary reports are submitted to the QI Committee for annual and semi-annual review if outlined in the previous pages.

Resources and Analytical Support

Systems

Resources currently available for support of the quality improvement activities include the following:

- FACETS System: System used for member enrollment, premium billing, claims payment, medical management, member services, phone log, and complaint tracking to generate provider directories. Data from this system populates our data warehouse and is used for a variety of purposes. Includes Aerial and iExchange for prior authorizations and medical management operations.
- Amisys Advance: Our Legacy system before FACETS for HEDIS look back
- Verisk Health Inc.: Decision support software used to support various QI activities. HEDIS data collection and reporting is done via Quality reporter.
- Grievance: Database used to track grievances. Includes various coding for report generation to use in tracking and trending data.
- Vistar: Credentialing database that houses all credentialing information.
- MetaStar: Our auditor of HEDIS data.
- DSS Research: Vendor used to conduct standard survey and analysis for HEDIS and CAHPS.
- Eloquence: Software used to generate letters.
- Other resources allocated as needed.

Analytical Support

The Health Care Informatics Manager is responsible for having the Health Care Informatics Team generate reports and statistical analyses to assist with HEDIS/CAHPS and other quality initiatives. This position reports to the Director of Quality and System Support.

Delegated QI Activities

We delegate specialty drug management and pharmacy benefit management. Some plans also have delegation for radiology management, occupational therapy, physical therapy, speech therapy, and chiropractic service review. The QI Committee monitors delegated agency performance through approval of the delegate's program, routine reporting, annual or more frequent evaluations, and/or on-site audits to determine whether the delegated activities are being

carried out in accordance with our standards. If monitoring reveals deficiencies in the delegate's processes, we will work with the delegate to set priorities and correct the concerns.

We also hold several provider credentialing delegations with various organizations. The Credentialing Committee monitors the delegated agency performance through initial review and approval of the delegate's program, routine reporting, and annual evaluations to determine whether the delegated activities are being carried out in accordance with the health plan's standards. If monitoring reveals deficiencies, the health plan will work with the delegate to establish a corrective action plan and resolve the deficiencies.

Collaborative QI Activities

One of the primary focuses of the QI Committee, in conjunction with the Quality Team and Code Governance Committee, is to perform a significant amount of outreach with provider groups. Each of the QI Specialists on the Quality Team reaches out to providers. The goals for outreach include quality improvement project collaboration, medical coding best practices, and iExchange outreach. This allows us to collaboratively identify areas in need of improvement, and work together on these projects to strengthen the level of service for our members. Ideally, we would like to see projects focusing on coordination and continuity of care between medical facilities and behavioral health services, and the expansion of availability to behavioral health services overall.

Medical Coding Best Practices
In 2016, the Medical Coding team began to identify common medical coding errors seen in claims from providers. The purpose is to find trends that can be easily corrected through outreach and education to reduce errors and speed up the claims process in general. In 2017, the Code Governance Committee will oversee outreach to these provider groups and measure the progress of the education by monitoring the coding practices seen on incoming medical claims.

iExchange Outreach
iExchange is a specialized online tool for submitting prior authorization requests and referral requests from our contracted providers to our organization. iExchange vastly reduces the turnaround time for requests and even offers automatic approval on some items.

Members of the Quality Committee are also members and active participants in the Wisconsin Chronic Disease Quality Improvement Project through the University of Wisconsin Population Health Institute, the Chronic Disease Prevention and Control Partnership through the Wisconsin Department of Health Services, and the Dane County Immunization Coalition.

Behavioral Health Care (BH)

Develop collaborative partnerships and initiatives to monitor and improve behavioral health care.

Objectives:

- Review the BH medical consultant roles and responsibilities annually.
- Actively participate with our BH network providers in identifying and resolving gaps of access for our members.
- Develop claims reporting and pharmacy data to identify the behavioral health needs of our members.
- Collaborate with our BH provider participants of the QI Committee to address improving member access to in-network BH providers.

Patient Safety

We foster a supportive environment to help practitioners and providers improve the safety of their practices through the following activities:

- **Clinical Practice and Guideline Process**: Establishes best practice criteria founded on national evidence based practice guidelines to reduce variation in the care delivered to members. Measurement of practitioner performance against guidelines occurs annually.
- **Credentialing/Re-Credentialing Process**: Ensures members are provided with a choice of qualified, competent practitioners and providers. The Credentials Committee meets monthly for the ongoing monitoring of practitioner sanctions and complaints between credentialing cycles.
- **Continuity and Coordination of Care**: Key indicators identifying potential problems are assessed to ensure quality of care.
- **Disease Management (DM) Program**: DM system monitors participants and alerts physicians when a member changes status to a higher risk.
- **Expedited Appeals Process**: Provides the assessment of, and action on, an appeal of a medical necessity denial based on the urgency of the needed care or service.
- **Medical Technology Request**: Allows review of the efficacy of the technology based on national research data and local medical practice.
- **Member Complaint Process**: Complaints are tracked and trended by category and reported semi-annually to the Quality Committee. When a complaint infers there is a potential for poor quality of care, the complaint is referred to the Medical Director and further review and investigation are completed. If there is a question of poor quality of care or unsafe practice, the occurrence is referred to the Credentials Committee.
- **Quality of Care Complaints**: This process documents members who address quality of care complaints to ensure patient safety.
- **Pharmaceutical Management Program**: Development and maintenance of drug usage criteria, assessment of the efficacy of new drugs, or a new use for an existing drug, monitoring of indicators relating to polypharmacy and misuse of medication. Monitoring of drug interactions to ensure patient safety.

Involvement of Designated Physician

Chief Medical Officer (CMO): The CMO is responsible for the oversight of Medical Affairs, including the QI Committee. The Chief Medical Director is

responsible for ensuring implementation of all aspects of the Medical Management Programs. The CMO reports to the Chief Executive Office and reports to the Executive Staff on Quality issues and updates as outlined in the QI Program Description.

Medical Director—Network and Quality: The Medical Director or Designee is responsible for ensuring the implementation of all aspects of the QI Program, as delegated by the CMO. The Medical Director chairs the QI, Credentialing, and the Medical Policy Committees. The Medical Director reports directly to the Chief Medical Officer.

Involvement of Designated Behavioral Health Care Practitioner

Behavioral Health Care (BH) Practitioners: The Behavioral Health Care Practitioners are involved in the BH aspects of the QI Program. BH practitioners serve on the QI, Medical Policy, Credentialing, and other ad hoc committees and teams. The BH practitioner must be a medical doctor or have a clinical Ph.D. or Psy.D., and may be a medical director, clinical director, participating practitioner from the organization, or behavioral health care delegate.

QI Committee Oversight

The Board of Directors designated the QI Committee to oversee our quality improvement activities. The QI Committee delegated to the Chief Medical Officer the responsibility for the direction and oversight of the QI Committee. The QI Committee annually reviews, makes recommendations for, and approves our QI Program. The Chief Medical Officer reports to the Executive Staff, which ultimately reports to the appropriate Board of Directors.

Annual QI Work Plan

The QI Program Work Plan is formulated annually by the Quality Specialist. The Work Plan includes the following:

- Yearly objectives
- Program scope
- Yearly planned activities
- Quality and safety initiatives
- Time frames within which each activity is to be achieved
- Staff member(s) responsible for each activity
- Evaluation of the QI Program

Serving a Diverse Membership

Objectives for serving a culturally and linguistically diverse membership are to:

- Evaluate membership demographics using the U.S. Census Report by county and CAHPS profile.
- Monitor availability of practitioners speaking a foreign language with sufficient fluency to treat a member who only speaks that language.
- Monitor response from the new member survey regarding cultural, ethnic, racial, or linguistic needs/preferences for practitioners.

- Monitor complaints related to cultural, ethnic, racial, or linguistic issues on a semi-annual basis.
- Monitor responses from the group enrollment questionnaire regarding languages spoken by employees.
- Maintain a policy on underserved populations and cultural competency.
- Maintain and monitor the Language Line Services agreement to support culturally competent communication.
- Monitor and review an action plan to address the cultural and linguistic needs of our membership if warranted by the above activities, including availability of appropriate educational materials and information updates for members.

We focus on improving cultural competency in materials and communications. We participate in UW Law School's Center for Patient Partnerships in their Case2Cause Program to address the ease of understanding and language used in our customer-facing documentation.

Serving Members with Complex Health Needs

We help members with multiple or complex conditions obtain access to care and services and coordinate their care through the Complex Case Management program. The Complex Case Management program annually assesses the needs of the member population, identifies candidates for the program through a series of algorithms and clinical intelligence rules, and then assists the identified population using an evidence-based program.

Clinical Outcomes

Clinical quality and outcomes will meet or exceed regionally and/or nationally established standards. Objectives:

- Design a project for the Quality Effectiveness Committee to address member medication adherence for the following conditions, Asthma, Hypertension, and Chronic Low Back Pain.
- Adopt and disseminate updated Clinical Practice Guidelines to be published on our website.
- Promote preventive care guidelines to improve HEDIS effectiveness such as well child visits and immunizations.
- Collaborate and participate with the Chronic Disease Quality Improvement Project for the State of Wisconsin to promote our Disease Management Program for Hypertension.
- Support member wellness through our Wellness/Prevention Program.
- Support and collaborate with network providers exchange of data analytics for population disease management.
- Analyze and address the existence of significant health care disparities in clinical areas.

Member Service Outcomes

Customers will experience the highest level of service. This includes positive interactions between our members and our staff. Staff will be trained to be well informed on how to best serve our members.

Objectives:

- Analyze CAHPS survey results annually and target improvement initiatives for low-scoring areas.
- Analyze member complaints and grievances monthly to initiate improvements as needed.
- Analyze Member Service and telephone access indicators semi-annually.
- Conduct an annual Practitioner Satisfaction Survey regarding utilization management process and implement improvements as needed.
- Survey key leaders of provider networks regarding clinical criteria for utilization management decisions and new technology.
- Build a robust website for members and providers to increase the health plan's transparency on member requirements and medical criteria.
- Continue Health Literacy initiatives to improve customer understanding and satisfaction with service provided.
- Continue to assess the need for culturally competent communication and provide information, training, and tools as needed.

QI Program Components

1. **Regulatory and Compliance**: WPS Health Insurance plans are designed to comply with all applicable state and federal legislation and regulations.
2. **Credentialing and Re-Credentialing**: We pre-contractually credential providers and UM delegations. Please see the Credentialing section of this manual for more detailed information regarding the process.
3. **Medical Management**: Our Medical Management Program is designed to monitor the appropriateness of all medically necessary and covered services for pre-service care, concurrent review, and post–service care delivered to plan members. A full description is included in the Medical Management section of this manual.
4. **Behavioral Health Care**: The scope of the Behavioral Health Care program is included in the Behavioral Health Care section of this manual.
5. **Disease Management (DM)**: The Disease Management Program identifies members with specific chronic conditions. Additional information is outlined in the Disease Management section of this manual.
6. **Supporting Community-Based Self-Support Tools**: The QI Committee's role is to work with community-based programs to assist individuals with chronic conditions to be able to better self-manage their conditions.

   The scope of the Community-Based Self-Support Tools Program consists of the following:

- Develop and participate in collaborative initiatives with our partners
- Develop working relationships with network providers' existing disease management programs

7. **Pharmacy Management**: The Pharmacy Management Program provides the framework for continual and systematic monitoring, assessment, and improvement of the medically necessary pharmaceutical products and services delivered to members. A detailed explanation of the program is included in the Pharmacy Management section of this manual.
8. **Quality of Care and Service**: We review and evaluate the quality of health care and service in all delivery settings, including both inpatient and outpatient care, by:
    - Performance of case review of quality of care issues
    - Review of medical record documentation
    - Evaluation of member and provider satisfaction
    - Compliance with clinical practice guidelines
    - Compliance with preventive care guidelines
    - Compliance with access and availability standards
    - Compliance with the health insurance administrative service standards
    - Evaluation of continuity and coordination of care members receive

Annual Quality Improvement Program Evaluation

The QI Program is evaluated annually by the QI Committee. The assessment and evaluation includes the following:

- Description of completed and ongoing quality improvement activities from the work plan that addresses quality and safety of clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety.
- Analysis of the results of quality improvement initiatives, including barrier analysis.
- Assessment and evaluation of the overall effectiveness of the Quality Improvement Program.

The QI Program evaluation findings are used to identify issues to demonstrate the impact of the program and to develop the Work Plan for the following year.

PROVIDER CONTRACTING

Contracted Providers: Provider Changes

To notify us of roster and location additions, deletions, or changes, complete the Practitioner Datasheet Form or Facility Datasheet Form found under Provider Forms | WPS or contact us by phone at 920-617-6325 to request an up-to-date copy.

If you leave your current practice to open or join a new practice, *it is possible that your new practice does not have a contractual agreement with WPS*. Contact the appropriate Provider Relations staff identified under the Main Contact Information section of this manual to verify contract status.

Subcontracts for Covered Services

Each subcontract with licensed persons or entities for the provision of covered services under a PPO Agreement to members will:

1. Require subcontractors to conform to all terms of the PPO Agreement applicable to the provider.
2. Allow WPS the right to pre-approve or disapprove the right of each individual licensed person or entity to provide covered services to members.

Subcontractors shall be defined as those individuals who are not employees of the provider, but provide services and seek payment under the PPO agreement.

Access

Providers will provide 24-hour telephone access to covered members. Preferred providers will have procedures in place to respond to covered members' calls and requests after normal business hours.

Discrimination

Providers will not discriminate in the treatment of covered members or in the quality of services delivered to covered members on the basis of race, sex, age, religion, place of residence, health status, disability, or source of payment. Providers will also observe, protect, and promote the rights of covered members as patients regardless of benefit limitations.

Compliance with Program/Provider Manual

WPS providers agree to participate, cooperate, and comply with materials outlined in the Provider Manual, including quality improvement activities. WPS providers agree to allow WPS to use performance data, such as, but not limited to, WCHQ, WHIO, etc., for analysis and peer comparison. Such data may be used to develop and evaluate quality improvement activities. Results may be shared via public reporting methods and other methods, including, but not limited to, web-based tools.

Non-Contracted Providers

Providers will not discriminate in the treatment of covered members or in the quality of services delivered to covered members. If interested in participating in the WPS provider network, please visit the How to Become a WPS Health Insurance Provider section of our website.

Exception: Chiropractors should contact Magellan Healthcare at 952-225-5732 if interested in joining the WPS provider network.

REVISIONS

Version	Date Revised
1.0	10/03/2013
1.1	03/20/2014
1.2	04/24/2014
1.3	09/01/2016
1.4	05/05/2017