PROVIDER MANUAL

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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, outpatient 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. WPS reserves the right to revise or alter the material and information detailed in this manual at any time.

About WPS

WPS is one of the largest health benefits providers in the state, and after more than 70 years remains Wisconsin's only not-for-profit insurer offering health plans statewide to the public and private sectors. With offices in Eau Claire, Green Bay, Madison, Milwaukee, and Wausau, and approximately 3,000 employees, we're deeply committed to this state and its citizens.

Insuring Wisconsin's Health Since 1946

WPS Health Insurance has deep roots in Wisconsin, grounded in events that occurred in the mid-1940s. It was a time when many people were having difficulty paying for necessary health care. In response, the State Medical Society developed a low-cost insurance product called the Wisconsin Plan, which permitted Wisconsin residents to budget the costs of health care. In 1946, the Medical Society established Wisconsin Physicians Service (WPS) to market and administer the plan.

From traditional PPO plans and self-funded administration to consumer-driven options, such as our HSA-qualified high-deductible plans, today WPS offers a broad array of health insurance plans to meet the needs of our group and individual customers. In addition, we offer supplemental insurance for seniors that helps them fill the gaps left by Medicare, and seniors can also choose our Medicare Part D plan.

Statewide Provider Network

Our comprehensive Statewide provider network includes over 15,000 physicians, specialists, clinics, and specialty care centers, along with 138 hospitals, in every county in Wisconsin, as well as counties in the bordering states of Illinois, Upper Michigan, Minnesota, and Iowa. WPS also offers national network coverage in 49 states outside of Wisconsin to meet out-of-state health care needs.

We round out our product offerings through our wholly owned subsidiaries, Arise Health Plan and The EPIC Specialty Benefits. Arise Health Plan, based in Green Bay, offers HMO and Point-of-Service plans to the group and individual markets. EPIC Specialty Benefits has been a provider of choice of non-medical group benefits for 25 years, offering term life, short-term disability, long-term disability, dental, vision, and voluntary benefits throughout the Midwest.

CONTACT WPS

Corporate

Mailing Address P.O. Box 8190
Madison, WI 53708

Office Address 1717 W. Broadway
Madison, WI 53713

Phone 1-608-221-4711
Business Hours Monday through Friday, 7:30 a.m. to 4:30 p.m. CT
Website wpsic.com

Member Services

Phone 1-608-221-4711
Toll-Free 1-800-765-4977
Fax 1-608-223-3626
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 Member 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

Correspondence Address:
Wisconsin Physicians Insurance
P.O. Box 8190
Madison, WI 53708

Provider Relations

Phone 1-608-977-6618
Fax 1-608-224-2279

Contact Provider Relations staff for:

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

Northwestern/North-Central Wisconsin

Janis Roesslein, Provider Relations Director
1-608-977-6661
Janis.Roesslein@wpsic.com

Stacy Willems, Provider Network Coordinator
1-608-977-6697
Stacy.Willems@wpsic.com

Northeastern Wisconsin

Kathy Stephenson, Provider Relations Director
1-920-617-6320
Kathy.Stephenson@wpsic.com

Karen Kabat, Health Plan Manager
1-920-490-6993
Karen.Kabat@wpsic.com

Southwestern/South-Central Wisconsin

Jayne Thompson, Health Plan Manager
1-608-977-6688
Jayne.Thompson@wpsic.com

Lori Olivares, Provider Network Coordinator
1-608-977-6643
Lori.Olivares@wpsic.com

Southeastern Wisconsin

Amy Anderson, Provider Relations Director
1-920-490-6930
Amy.Anderson@wpsic.com

Jessie Evans, Provider Network Coordinator
1-608-977-6582
Jessie.Evans@wpsic.com

Provider Credentialing

Sue Hastings, Credentialing Manager
1-920-490-6952 (Direct)
1-920-490-6955 or 1-608-221-5479 (Fax)
Sue.Hastings@AriseHealthPlan.com

Contact Provider Credentialing for:

- Initial credentialing or re-credentialing criteria
- CAQH questions

Independent Chiropractors

Please contact HSM directory regarding contracts and/or credentialing.
HSM, Inc.
7805 Hudson Road, Suite 190
St. Paul, MN 55125

Main Phone	1-952-225-5700
Toll-Free	1-800-432-3640
Fax	1-888-656-1913

Medical Management

Direct	1-800-333-5003
Toll-Free	1-800-333-5003
General Fax	1-608-226-4711
Prior Authorization Fax	1-608-226-4777

Contact Medical Management for:

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

Electronic Claim Submission

The WPS Electronic Data Interchange (EDI) department has a dedicated staff whose primary function is to consult and assist providers on electronic processes. Our staff is experienced in dealing with a variety of provider specialties, billing services, and software vendors.

Phone	1-608-221-7115
Toll-Free	1-800-782-2680
Email	edi@wpsic.com
Web	wpsic.com/edi
Hours	Monday through Thursday, 7:55 a.m. to 4:30 p.m. CT Friday, 7 a.m. to 4:30 p.m. CT Saturday, 8 a.m. to noon CT

PRODUCT AND BENEFIT PLANS

With quality coverage, affordable plan designs, and the ability to offer a wide range of benefit and network choices, WPS offers a wide array of plans to meet every need. We administer self-funded group plans and insure fully insured plans for employers, individuals, families, and employers. Benefit options for employer groups vary depending on whether the employer is small (2-50 employees) or large (51+). 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 a broad freedom of provider choice. Members of PPOs are free to receive care from both 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.

WPS offers individual, family, and employer-sponsored PPO plans featuring the Statewide Network or one of our affordable regional network options.

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 offer lower premiums and a health savings account that lets members budget and pay for qualified medical expenses using tax-free dollars.

Focused Plan

WPS offers local network options within defined service areas throughout the state. These regional networks offer broad access to providers offering a full range of health care services.

Aspirus Network

The Aspirus Network features Aspirus Wausau Hospital and more than 400 Aspirus primary and specialty care providers. Available in the following counties: Langlade, Lincoln, Marathon, Taylor, and Wood.

Southern Network

The Southern Network features Dean Clinic 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 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.

Wisconsin Medicare Supplement (Medigap) Plan

Supplemental Medicare is 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 that cover Medicare deductibles and coinsurance.

MEMBER RIGHTS AND RESPONSIBILITIES

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

Member Rights

WPS members have the right to:

- Be treated with respect and recognition of their dignity and their right to privacy. Members also have the right to the privacy of their medical information unless they allow the release of such information.
- Participate in any decision-making regarding their health care.
- Have a candid discussion of appropriate or medically necessary treatment options for their medical condition.
- Receive the right care at the right level at the right time by the right type of provider for their medical condition.
- Receive information about preventive health care that is age and sex specific, and information about remaining as healthy as possible, including self-care and maintenance care for specific chronic diseases.
- Receive care according to federal and state mandates.
- Voice complaints or appeals about service from WPS Health Insurance or about care received.

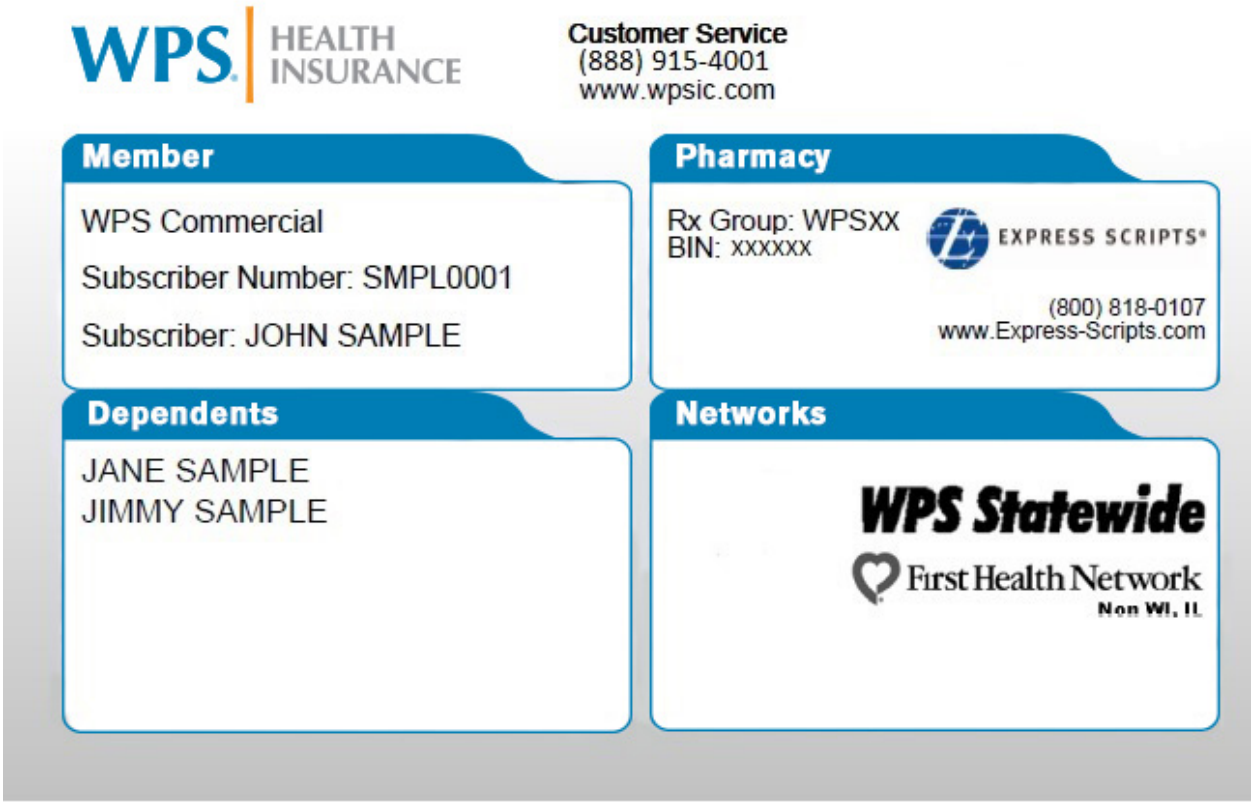
Member Responsibilities

WPS plan members are responsible for:

- Providing, to the extent possible, information WPS Health Insurance and their physician or health care provider need to care for them.
- Being aware of their health care coverage and requirements/limitations under their certificate of coverage, including, but not limited to, pre-certification or prior authorization requirements and exclusions.
- Asking questions about their diagnosis, treatment plan, and how best to manage their health.
- Following the plans and instructions for care on which they have agreed with their physician or other health care provider.

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, WPS telephone numbers, and the WPS claim submission address. WPS member ID numbers are randomly generated.



MEMBER GRIEVANCE/APPEAL PROCESS

This section includes the grievance/appeal rights and the grievance procedure 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.

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

The Grievance/Appeal Committee is composed of four 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 their authorized representative who files a grievance/appeal will be notified of their right to appear in person, or to present written or oral information before the Grievance/Appeal Committee. WPS will send the covered person written notice of the time and place they may appear before the Grievance/Appeal Committee. Following a thorough review of all information received for the grievance/appeal, the Grievance/Appeal Committee votes on the resolution of the case. A resolution letter outlining the Grievance/Appeal 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 or Appeal

Only WPS members may request an appeal of a claim or medical decision. The attending provider, or facility rendering service, may submit a grievance/appeal, but ONLY with signed authorization from the patient.

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

Urgent or Expedited Grievance/Appeals

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

1) 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, or
2) 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, or
3) 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 (IR). Members may request an IR 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, or
- Investigative.

This includes the denial of a request for a referral for out-of-network services when the insured requests health care services from a provider who does not participate in the insurer's provider network, because the clinical expertise of the provider may be medically necessary for treatment of the insured's medical condition, and that expertise is not available in the insurer's provider network.

Members may also request an IR 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 53708

Office of the Commissioner of Insurance (OCI)

In addition to a WPS 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 Telephone: 1-608-266-0103
Toll-Free: 1-800-236-8517
Website: www.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
- 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)
- Physical Therapists (PT)
- Speech Therapists (ST)
- Speech 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).

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
- Nursing homes
- Free-standing surgical centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory center

WPS will confirm that the organizational provider:

- Meets all state and federal licensing and regulatory requirements in good standing; and
- Has proof of adequate liability insurance; and
- Has evidence of accreditation by a recognized accrediting body or current CMS certification; or meets WPS standards of participation with an overall site visit/ file audit score of at least 80%.

Provider Credentialing Rights

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.

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 Electronic Data Interchange (EDI) department has a dedicated team whose primary function is to consult and assist providers with the EDI process. 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 call our EDI Marketing staff at 1-800-782-2680 or visit the EDI section of the WPS website.

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
- Amount billed for those services
- Where those services were rendered
- Who rendered those services

The above data is 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, version 9 (ICD-9) for Diagnosis and Hospital Inpatient Procedures for dates of service up to October 1, 2015, and version 10 (ICD-10) for dates of service October 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:

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 non-compliant 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 appeals
- Internal and external claim audits
- Pre-existing conditions (grandfathered and Alternate Choice 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 should be submitted as soon as possible following the date of service to expedite the claim payment process.

If WPS is the secondary payer, the timely filing period will not begin until the date the primary payer's responsibility was calculated. Claims must be received within the time frame specified in your Preferred Provider Agreement. 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 and the capability to view edit results and rationale. Providers are able to 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 for greater transparency of the code combination edits applied by WPS.

Reimbursement Policies

You may view our reimbursement policies on the provider portal of the WPS website. Please choose Providers 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 that identifies the correct claim situation, 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.

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 re-file the claim using the WPS original claim identification number referenced on your 835 remit.

Paper Claim

If you need to correct or resubmit a corrected claim via paper submission, please attach it to the Corrected Claim Cover Sheet found on the Provider Forms area of our website.

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
1717 W. Broadway
P. O. Box 8190
Madison, WI 53708-8190

PRIVACY POLICIES

Personally Identifiable Information

At WPS, we take our customers' privacy seriously and understand that visitors to our websites need to be in control of their personally identifiable information (name, email address, postal address, etc.).

We will not gather personally identifiable information about our members unless they specifically and knowingly provide this information to us. For example, health care providers and prior-authorized individuals may submit authenticated requests in order to access secured areas of our website. In these cases, the personally identifiable information is only used for authorized retrieval of the requested data or for statistical purposes in order to analyze visitor behavior to measure customer interest in various areas of our website.

To access confidential information on the website, the user must first self-authenticate. This is accomplished by entering a member number/user ID and password. This user ID and password is encrypted, sent to wpsic.com, decrypted, and verified against a back end database. If everything matches, the user is permitted to access the information.

To secure the site, any sensitive information that passes between the Web browser and wpsic.com is encrypted with 128-bit SSL. This encryption strength is one of the highest available today.

We will not disclose, give, sell, or transfer any personally identifiable information to third parties.

HIPAA and Protected Health Information (PHI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is designed to make health coverage more portable for individuals who change jobs or health plans by limiting the coverage exclusions that can be imposed when such a change occurs. HIPAA also contains privacy provisions designed to protect the confidentiality and security of Protected Health Information (PHI).

Title I of HIPAA deals with health care access, portability, and renewal. Provisions regarding such things as special enrollment rights, creditable coverage, and pre-existing conditions are found in Title I.

Title II of HIPAA, which contains a section entitled “Administrative Simplification,” includes provisions designed to reduce health care costs by standardizing claims processing, as well as provisions designed to improve the privacy and security of health information.

Transactions and Code Sets Standards

Transactions are electronic exchanges involving the transfer of information between two parties for specific purposes. For example, a health care provider will send a claim to a health plan to request payment for medical services. HIPAA named certain types of organizations as covered entities, including health plans, health care clearinghouses, and certain health care providers.

In the HIPAA regulations, the Secretary of Health and Human Services (HHS) adopted certain standard transactions for Electronic Data Interchange (EDI) of health care data. These transactions are: claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits, and premium payment. Under HIPAA, if a covered entity conducts one of the adopted transactions electronically, they must use the adopted standard. Covered entities must adhere to the content and format requirements of each transaction.

Under HIPAA, HHS also adopted specific code sets for diagnoses and procedures to be used in all transactions. The HCPCS (Ancillary Services/Procedures), CPT-4 (Physicians Procedures), CDT (Dental Terminology), ICD-9 (Diagnosis and Hospital Inpatient Procedures), ICD-10 (as of October 1, 2014), and NDC (National Drug Codes) codes with which providers and health plan are familiar, are the adopted code sets for procedures, diagnoses, and drugs. Finally, HHS adopted standards for unique identifiers for Employers and Providers, which must also be used in all transactions. Information about the identifiers can be found at www.cms.gov.[1]

[1] Source: CMS Transaction & Code Sets Standards

Privacy Rule

The HIPAA Privacy Rule establishes in law the basic principle that an individual's health information belongs to the individual and, with several exceptions, that covered entities cannot use the information without permission from that individual.

The HIPAA Privacy Rule applies to “health plans,” “health care clearinghouses,” and most “health care providers.” Collectively, these categories are referred to as “covered entities.” Health plans are defined to include health insurers, HMOs, employer-sponsored group health plans, Medicare, Medicaid, and TRICARE, among others.

Unique Health Identifiers

HIPAA requires that employers have standard national numbers that identify them on standard transactions. The Employer Identification Number (EIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002.

HIPAA requires that health care providers have standard national numbers that identify them on standard transactions. The National Provider Identifier (NPI) is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses use the NPIs in the administrative transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty.[2]

[2] Source: HHS Understanding HIPAA Privacy

Security Standards

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.[3]

[3]Source: HHS Understanding HIPAA Privacy

GLOSSARY OF TERMS

Medical Management Definitions

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

Certification: Determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

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

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

Emergency Medical Care: Health care services provided by a health care provider to treat a member's medical emergency.

Medical Emergency: 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.

Evidence-based: Recommendations based on valid scientific outcomes research, preferably research that has been 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: The use of any health care services for a member's illness or injury that, at the time it is used, meets one or more of the following:

1. Requires approval that has not been granted by the appropriate federal or other government agency, such as, but not limited to, the Federal Food and Drug Administration (FDA); or
2. Isn't yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or
3. Is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, II, or III clinical trial, except for those required by law; or (d) an ongoing review by an Institutional Review Board (IRB); or
4. Doesn't have either: (a) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (b) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (JAMA), concerning such treatment, service, or supply and reflecting its recognition and reproducibility by non-affiliated sources WPS determines to be authoritative.

The following are generally covered subject to the terms and conditions of the member's policy:

1. Investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended; and
2. Drugs which by law require a written prescription used in the treatment of cancer that may not currently have FDA's approval for that specific diagnosis but are listed

in recognized off-label drug usage publications as appropriate treatment for that diagnosis.

The determination of whether a health care service is experimental or investigative shall be made by WPS in our sole and absolute discretion. In any dispute arising as a result of our determination, such determination shall be upheld if the decision is based on any credible evidence. In any event, if the decision is reversed, the limit of our liability under the policy or on any other basis shall be to provide policy benefits only and neither compensatory nor punitive damages, nor attorney's fees, nor other costs of any kind shall be awarded in connection therewith or as a consequence thereof.

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

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

1. Consistent with the symptom(s) or diagnosis and treatment of the member's illness or injury;
2. Furnished for an appropriate duration and frequency in accordance with accepted medical practice to treat that illness or injury;
3. The most appropriate health care service or location for providing such health care service, which can be safely provided to the member and accomplishes the desired end result in the most economical manner; and
4. Supported by information contained in the member's medical records or from other relevant sources that may not currently have FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis.

A service, supply, treatment, or facility may not be considered Medically Necessary, even if the provider or practitioner has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

Non-Certification: A determination by WPS that an admission, extension of stay, or other health care or pharmacy service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the applicable health benefit plan.

Prospective Review: Also referred to as "prior authorization," this is the process of receiving written approval from WPS for certain services or products prior to the service or product being rendered to the member. Prior authorization and pre-certification are

included in the definition or prospective review. Prospective review can also include prospective prescription drug utilization review.

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.

Retrospective Claim: A claim presented after services have been provided (i.e., a post-service claim) and presented for consideration and payment under a contract or policy.

Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the patient.

Urgent Care: Any request for care or treatment where the application of the time periods for making non-urgent care determinations could result in the following circumstances:

1. Seriously jeopardize the life, health, or safety of the member or others due to the member's psychological state, or
2. In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Behavioral Health Definitions

Day Treatment Programs: Nonresidential programs for alcohol and drug dependent members and for treatment of nervous or mental disorders, which 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: (a) services for the treatment of nervous or mental disorders, alcoholism, or drug abuse that are directly provided to a member who is a bed patient in the hospital; and (b) services for the treatment of alcoholism or drug abuse that are directly provided to a member in a facility with a program certified by the Department under Section HFS 61.63, Wis. Adm. Code, as amended. However, this definition shall not include those inpatient hospital services for detoxification of drug addiction or alcohol dependency.

Outpatient Services: Nonresidential services for the treatment of nervous or mental disorders, alcoholism, or drug abuse problems directly provided to a member and, if for the purpose of enhancing the member's treatment, an immediate family member by any of the following:

a. A program in an outpatient treatment facility, if both the program and facility are approved by the Department and established and maintained according to rules promulgated under Section 51.42 (7)(b), Wisconsin Statutes, as amended;
b. A licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office;
c. A psychologist licensed or certified by the state in which he/she is located;
d. A licensed mental health professional practicing within the scope of his/her license under ch. 457 and applicable rules; or
e. A health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism, or drug abuse within the scope of that license.

Residential Treatment Programs: Therapeutic programs for treatment of nervous or mental disorders and alcohol and drug dependent members, including therapeutic communities and transitional facilities.

Transitional Treatment Arrangements: Services for the treatment of nervous or mental disorders, alcoholism, or drug abuse that are directly provided to the member in a less restrictive manner than are inpatient hospital services, but in a more intensive manner than are outpatient services, if both the program and the facility are approved by the Department as defined in the Section Ins 3.37, Wis. Adm. Code, as amended.

Transitional treatment services are services provided by a health care provider, and certified by the Department for each of the following (except h.) below:

a. Mental health services for covered adults in a day treatment program;
b. Mental health services for covered children and adolescents in a day treatment program;
c. Services for members with chronic mental illness provided through a community support program;
d. Residential treatment programs for treatment of a member's nervous or mental disorders and for alcohol or drug dependent members or both;
e. Services for alcoholism and other drug problems provided in a day treatment program;
f. Intensive outpatient programs for narcotic treatment services for opiate addiction;
g. Coordinated emergency mental health services for members who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided; and
h. Out-of-state services and programs that are substantially similar to a. through g. above if the provider is in compliance with similar requirements of the state in which the health care provider is located.

The criteria that 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:

a. The program is certified by the Department;
b. The program meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;
c. The specific diagnosis is consistent with the symptoms;
d. The treatment is standard medical practice and appropriate for the specific diagnosis;
e. The treatment plan is focused for the specific diagnosis;
f. The multidisciplinary team running the program 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 help determine the medical necessity of such program or service:

a. A summary of the development of the member's illness and previous treatment;
b. A well-defined treatment plan listing treatment objections, goals and duration of the care provided under the transitional treatment arrangement program; and
c. A list of credentials for the staff who participated in the transitional treatment arrangement program or service, unless the program or service is certified by the Department.

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:

a. Requested by a preferred physician;
b. Received by WPS in writing or by telephone prior to rendering of the health care services;
c. For health care services that are not otherwise available from a preferred provider;
d. Approved in writing by WPS; and
e. Valid for the period of time specified by WPS.

MEDICAL POLICIES AND PROCEDURES

WPS creates internal Medical Policies and Procedures for certain services. These policies are coverage guidelines that assess the medical necessity of a service or the experimental/ investigational status of the service based on the existing medical peer-reviewed literature and/or the best available expert consensus. Policies are approved by the WPS Medical Policy Committee, which consists of support staff and several primary care and specialty physicians in the WPS network. Policies are reviewed and, if needed, updated, on a yearly basis.

WPS Medical Policies and Procedures are created using the following principles using evidence-based medicine:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the investigational settings.

You may email WPS Medical Affairs at medical.policies@wpsic.com with questions or inquiries regarding WPS medical policies and procedures.

Review Process for Medical Services

Rehabilitative Therapy Services

Requests are submitted via the HSM Web portal on the WPS iExchange website or via fax at 1-888-656-2204.

All Other Medical Services

Requests are received via iExchange, fax, or phone.

Turnaround

- Urgent reviews: A decision is made within 72 hours.
- Non-urgent reviews: A decision is made within 15 days once sufficient clinical information is received to render a decision.

Review Process

A reviewer (nurse or other health professional) will apply the appropriate criteria either from a medical policy or other recognized source.

- If criteria are met, the reviewer will approve the request and notify both the provider and member.
- If criteria are not met, the request will be forwarded to a physician for review. The physician will determine if additional information is needed. If so, it will be requested. If not, he/she will approve or deny the request. Only a physician can deny a request.
- If the request is denied, both the provider and member are notified in writing. Additionally, they are made aware of their grievance/appeal rights.

MEDICAL MANAGEMENT

Overview

The WPS Medical Management Program is designed to ensure that members receive coordinated, cost-effective care that is delivered according to evidence-based guidelines, and that services are provided at the appropriate time and level of care. The program was developed in collaboration with internal and external clinicians and the WPS Medical Management Team. All components of the program comply with Federal and State regulations and strive to meet the nationally recognized standards set by URAC.

Our Utilization Management program has been accredited by URAC since 1996 and recently received continued full three-year reaccreditation following an on-site review by URAC. Our experienced staff is supported by our Medical Director and a team of board-certified specialists who review cases, develop policies, and assist with program development.

Principle Components

- Utilization Management
- Integrated Care Management
- Pharmacy Management

The WPS Medical Management Department is staffed by licensed registered nurse care specialists, nurse reviewers, a pharmacist, behavioral health and physical medicine specialists, physicians, and other non-licensed personnel who are available to our network physicians.

Objectives

1. Provide a structured process to monitor and continually improve the delivery of services to our members by:
   - Establishing health management processes that ensure the delivery of high-quality service across the continuum of care;
   - Creating a process for inclusion of stakeholder and customer feedback;
   - Conducting inter-reviewer reliability audits of department staff to ensure consistent, fair decision-making;
   - Submitting medical policies for external code review to ensure compliance with national coding standards;
   - Incorporating nationally recognized guidelines in decision algorithms to provide external support for internal decision-making;
   - Providing access to external review agencies to get accurate review of sub-specialty services where internal expertise is not available;
   - Incorporating analyses from claims and clinical data to improve processes, support decision-making, provide information to customers, and identify members who would benefit from our programs; and
   - Providing access to appropriate grievance and appeal processes.

2. Improve clinical outcomes by:
   - Collaborating with internal and external clinicians to create and implement clinical practice guidelines which are evidence-based and address key health needs across the continuum of care;
   - Providing support during transitions of care;
   - Providing access to highly qualified medical and behavioral health staff;
   - Using analytical expertise to identify members with significant gaps in care and incorporating this information into the care management process;
   - Measuring program performance using metrics from Health Employer Data Information Set (HEDIS), URAC, and external care management software vendors, as well as those created internally;
   - Complying with URAC standards for the accreditation of health plans; and
   - Providing access to wellness coaches who can assist members who want support related to creation of exercise plans, making healthier eating choices, reducing stress, and quitting smoking.

3. Ensure that the most cost-effective services are delivered to the right member at the right time by:
   - Providing timely prior authorization review of outpatient and inpatient services and medications;
   - Ensuring that services are delivered in accordance with the member's benefits;

- Determining that the proposed services are medically necessary and that they are not experimental or investigational;
- Providing concurrent review of inpatient and residential stays;
- Making retrospective review determinations based on information provided on claims;
- Providing integrated care management to move members toward their best possible health status, educate them about their diseases, support them during complex episodes of care, and make them active participants in their health care decision-making;
- Coordinating care with the member's primary care physician, specialists, and other clinicians; and
- Conducting appropriate analyses to understand the utilization patterns of the members WPS serves.

The WPS Medical Management Program was developed and is maintained by the WPS Medical Affairs Department. The WPS Medical Director has responsibility for overseeing key aspects of the program, such as:

- Committees and programs including the Medical Policy Committee, the Quality Program, and the Credentialing Committee;
- Assistant Senior Medical Director and Physician Advisors who make the medical necessity determinations and who provide peer-to-peer consultations with external physicians providing care to our members;
- Policies that govern prospective, concurrent, and retrospective review, as well as the integrated care management program; and
- Medical necessity denial decisions, as well as those related to the determination of whether a service is experimental or investigational.

The WPS Medical Director will consult with appropriate board-certified specialists if the medical necessity reviews require expertise that is out of his expertise and that of the Assistant Senior Medical Director and Physician Advisors.

The WPS Medical Management Program is supported by the following resources and tools:

- InterQual® care management criteria
- Prest and Associates behavioral health criteria
- Internally developed medical policies and guidelines
- National Comprehensive Cancer Network® (NCCN) guidelines
- UpToDate®– an evidence-based decision support tool.
- Internal clinical experts, including the Senior Medical Director, Assistant Senior Medical Director, Physician Advisors, a Pharmacist, registered nurses, and behavioral health and physical medicine specialists
- Contracted external physician review organizations
- Apollo® guidelines

- Centers for Medicare & Medicaid Services (CMS)

PHARMACY SERVICES

WPS offers a comprehensive prescription drug program that allows practitioners to manage their patients appropriately. Program leadership is provided by the WPS Director of Pharmacy and the WPS Medical Director.

The WPS Pharmacy Management Program is overseen by the WPS Corporate Quality Management Committee and is administered by our pharmacy benefit management vendor, Express Scripts.

The Pharmacy Management Program is reviewed annually and updated as needed. Changes to the program are communicated to practitioners via the WPS website (or by hard copy only upon request).

Pharmacy Benefits

WPS contracts with Express Scripts to process pharmacy claims. Express Scripts is also our exclusive provider of mail-order pharmacy services.

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

The Provider area of our website has additional pharmacy resources to help you, including:

- WPS Drug Prior Authorization list
- WPS Preferred Drugs Guide
- Tip sheets for lowering prescription drug costs and preventing medication mix-ups
- Information on specialty pharmacists at Express Scripts

Drug Formulary

WPS uses a formulary designed and maintained by Express Scripts. Preferred Prescriptions®/RX Selections™ is the Express Scripts formulary list of medications that may be covered under a WPS member's prescription drug plan. The formulary list was reviewed by an independent group of practicing doctors and pharmacists, and it contains medications made by most pharmaceutical manufacturers. It includes medications for many covered conditions.

View the Express Scripts formulary list of *most commonly prescribed drugs* by visiting the Pharmacy/Rx page on the provider area of the WPS website. Please note this list is only a guide and does not guarantee coverage or contain a complete list of formulary and non-formulary drugs.

Drug Prior Authorization

A limited number of formulary drugs must meet specific criteria before they will be considered a covered benefit. The practitioner may be required to submit certain medical information to either WPS or Express Scripts to request prior authorization.

The WPS Drug Prior Authorization list is posted on our website and provides instruction regarding who should be contacted for the specific drug being requested. The practitioner's office is always notified whether or not the drug authorization request is approved.

Drug prior authorization information may be mailed or faxed to:

WPS Prior Authorization
P.O. Box 8190 Madison, WI 53708-8190
Fax: 608-226-4777

> Providers should submit requests for drug prior authorization via iExchange. Please see the iExchange section of this manual for more information.

For Express Scripts reviews, providers should call 1-800-753-2851. The practitioner's office is always notified as to whether or not the drug authorization request is approved.

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

If a drug prior authorization request has not been requested, or the authorization has been denied, the pharmacy will not be able to file the drug claim under the member's prescription benefit, and the member will be responsible for the entire cost of the prescription.

Some drugs are not taken every day, for example, migraine medications. Therefore, the amount per copay is limited to what would typically be needed for that condition. If the pharmacy is submitting a quantity larger than what is allowed, the prescription will not process.

Retail pharmacies are only able to dispense up to a continuous 30-day supply of medication. The prescription will not process if the pharmacy is trying to dispense greater than this amount.

Three-Tiered Drug Benefit

Most members have a three-tier drug benefit. The copay/coinsurance levels vary based upon the formulary status of the drug prescribed and categorized into tiers:

- Tier 1: Generic drugs on the formulary (lowest copay/coinsurance)
- Tier 2: Brand name drugs on the formulary
- Tier 3: Brand name drugs not on the formulary (highest member copay/coinsurance)

Specialty Drugs

Some members also have a specialty drug tier. Specialty drugs are identified by Express Scripts and generally have the following characteristics:

- High cost,
- Limited distribution, or
- Unique handling requirements.

HSA Drug Coverage

Some members have a federally qualified high-deductible health plan where both medical and pharmacy claims accrue to the same deductible and out-of-pocket. In these situations, WPS tracks the member's medical and pharmacy claims and applies the appropriate deductible and/or coinsurance accordingly.

Covered Drugs

Drugs covered under the prescription drug benefit are FDA-approved drugs that, by law, require a prescription from a licensed practitioner, are medically necessary, and meet all provisions of the member's benefit plan.

Federally mandated covered drugs (for example, contraceptives, aspirin in certain situations, folic acid, etc.) are covered at 100%. To be eligible for coverage, WPS requires that any covered non-prescription drug 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)
- Investigational 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 pre-service authorization is obtained

- Any medical supply not noted elsewhere
- Injectable medications, except as determined by WPS or its designee
- Drugs used for impotence, or whose primary use is impotence, or to enhance sexual activity
- Drugs used for smoking cessation, unless specifically covered in the member's certificate

Generic Substitutes

When an FDA-approved generic to 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 are chemically identical to their brand name counterparts. Pharmacists will dispense the generic medication in this situation. If the member requests the brand, they will be responsible for the appropriate copay/coinsurance, plus the difference in cost between the brand and the generic.

Drug Therapy – Using the Most Effective Place of Service

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. These determinations are made by the WPS clinical staff.

Should the member and/or provider choose to use a more expensive place of service to administer a drug, WPS will only reimburse that drug at the rate it would have paid in the lower-cost setting. The member is responsible for all additional charges, and the provider must seek any excess charges from the member.

UTILIZATION MANAGEMENT

Prior Authorization

Prior authorization is part of WPS' Utilization Management program. Prior Authorization is the process of obtaining WPS authorization *prior* to the member receiving services. The purpose of the prior authorization function is for WPS to determine member eligibility, benefit coverage, medical necessity, and appropriateness of services. Approval is not a guarantee of payment and is subject to all other policy limits and provisions.

WPS expects participating providers to coordinate with their patients to ensure all necessary clinical information is submitted with the prior authorization request. Incomplete requests may result in processing delays or denial of services. Ultimately, it

is the member's responsibility for assuring that the required prior authorization is received before health care services are provided.

Please allow up to 15 calendar days for the review process. Prior authorization requests may be submitted to WPS via fax, mail, or iExchange (please see the iExchange section of this manual for more information).

If prior approval is not received, services may be denied in full or processed at a lower level of benefit. Benefits and requirements may vary based on the type of plan the member has purchased.

Below is a list of health care services for which prior authorization is required or recommended.

Prior Authorization REQUIRED

- Inpatient Admissions
  - Admission to a hospital for treatment of an illness or injury
  - Admission to a residential treatment program for treatment of alcoholism, drug abuse, or nervous or mental disorders
  - Members must notify WPS of admissions at least three (3) business days prior to the proposed admission date for non-emergency admissions for determination of medically necessary days for which benefits are payable
- Home intravenous therapy/infusion therapy when performed in the home and prescribed by a physician
- Transplant services
- Non-emergency licensed professional ambulance services
- Prosthetics with a total purchase price greater than $1,000
- Durable medical equipment that will be rented for more than three months or with a total purchase price greater than $500, including, but not limited to:
  - Wheelchairs;
  - Oxygen equipment (including oxygen); and
  - Hospital-type beds
- Pain management procedures as follows:
  - Percutaneous intervertebral disc procedures (intradiscal electrothermal therapy (IDET), intradiscal electrothermal annuloplasty (IDEA),percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), nucleoplasty, laser assisted disc decompression (LADD), percutaneous disc decompression, chemonucleolysis;
  - Ablation (denervation) of the facet joint nerves;
  - Facet joint injections and medial branch nerve blocks;

    - Selective nerve root blocks and epidural injections, other than epidural injections provided to the pregnant member in connection with labor or delivery of a newborn child or due to surgery;
    - Sacroiliac joint injections; and
    - Artificial intervertebral disc replacement (lumbar artificial disc replacement (LADR)) and intervertebral disc prostheses
- Genetic testing services for treatment of an illness
- Specialty drugs provided by a health care provider other than a pharmacy

Prior Authorization RECOMMENDED

Below is a list of services for which WPS recommends the member receives a prior authorization prior to receiving. While not required, these services may be reviewed for medical necessity and appropriateness of care upon receipt of claim if not authorized prior to the care being rendered.

- New medical or biomedical technology;
- Services performed as part of a research study or clinical trial;
- Inpatient and outpatient hospice care;
- Home care;
- Skilled nursing care in a licensed skilled nursing facility;
- Varicose vein treatment;
- Exercise programs;
- Acupuncture;
- Evaluation and treatment of sleep disorders, such as polysomnograms (sleep studies);
- Outpatient physical, speech, occupational, massage, and respiratory therapy up to a combined maximum benefit limit shown in the member's certificate. Covered therapy must:
    - Be expected to provide significant measurable gains that will improve the member's physical health;
    - Be performed by: (a) a physician; (b) a licensed physical, speech, occupational, or respiratory therapist; (c) any other health care provider approved by WPS; and
    - Be directed by the member's ordering physician
- PET scans; and
- MRAs.

Timeline

- **Urgent:** Determination to be made as soon as possible, but no later than 72 hours from the receipt of request to completion. Letter must be sent within one business day of determination.

- **Non-Urgent:** Determinations to be made within 15 calendar days from the receipt of request to sending notification letters. Letter must be sent within one business day of determination.

Denial Notification

If the decision is made to deny a service, the notification sent to the member and the requesting provider will include the following items:

- The specific reason for the denial
- A description of the grievance/appeal rights, including the right to submit written comments, documentation, or other information relevant to the grievance/appeal
- For urgent pre-service or urgent concurrent denials, a description of the expedited grievance/appeal process

Concurrent Review

Concurrent Review is utilization management conducted during a patient's hospital or facility stay or course of treatment (including outpatient procedures and services). These reviews are sometimes called "continued stay review."

If a member needs additional days reviewed and authorized after an inpatient stay in a hospital, LTAC, or skilled nursing facility or inpatient hospice, the member (or the provider on behalf of the member) should call or submit a fax with clinical information to utilization management staff prior to the expiration date of the initial certification.

For requests to extend a current course of treatment, the determination is issued within:

- 24 hours of the request, if the request for the extension was received at least 24 hours before the expiration of the currently certified period or treatments; or
- 72 hours of the request, if the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.

Note: Unless a request for an extended stay is received 24 hours before the anticipated discharge date, the 72-hour time frame is used.

Retrospective (Post-Service) Review

A retrospective review is a review conducted after services (including outpatient procedures and services) have been provided to the patient.

Post-service determinations are to be made within 30 calendar days from the receipt of request to completion. (Notification letters are sent within the 30 calendar-day timeframe and within one business day of determination.)

Lack of Information

For reasons out of our control (for example, clinical information requested, but not provided), WPS may grant a one-time extension to standard turnaround times for the following review requests: 1) Non-Urgent Prior Authorization Review or 2) Retrospective Review.

The provider and member will be notified of the need for up to a 15 calendar-day extension within the 15 calendar days of the initial request, including the circumstances requiring the extension.

The written notice of lack of information extension to the patient and provider/facility must specifically describe the required information, and the patient must be given at least 45 calendar days from the receipt of notice to respond to WPS' request for more information.

Behavioral Health

Behavioral Health Benefits

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

No benefits are payable for charges for outpatient services provided to, or received by, a member as an immediate family member of a patient which do not enhance the outpatient treatment of another member who is also insured under the policy.

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

Outpatient Behavioral Health Treatment Plans

To submit a request for outpatient treatment, please fill out the appropriate form below and fax to 1-608-226-4777.

Certification Request/Psychological and Neuropsychological Testing
Outpatient Behavioral Health Treatment Request Form

Autism Treatment Plans

To submit a request for autism services, please fill out the applicable form below and fax to 1-608-226-4777

Professional Staff Update Notification
Autism Spectrum Progress Report form

iExchange® Web Portal

iExchange is a program offered by WPS that allows clinical staff to electronically submit prospective review requests for inpatient and outpatient services to WPS using the internet. iExchange cases are expedited, allowing members and providers to be notified of the status of their case in a timelier manner.

WPS strongly recommends that providers submit prospective review requests via the iExchange Web Portal. We offer both telephonic and live training to assist your staff so they can be prepared for future submissions of cases. Watch the iExchange demonstration now.

Benefits of iExchange

- Direct electronic submission
- Immediate feedback from WPS
- Assignment of a Case ID number
- Monitoring the status of the request (for example, Auto-approval; Pended for review)
- Communication with WPS staff through iExchange
- Alerts when the case has been updated
- Ability to electronically attach medical records to iExchange
- Printable requests/approvals for the provider

By giving providers access to the iExchange web portal, WPS hopes to improve communication and collaboration with our provider community, recognizing that your patients are our members. Your patients will often receive automatic case approvals in real time.

Enroll in iExchange

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

Email: iExchange@wpsic.com
Phone: 1-800-333-5003 (ask to speak with an iExchange representative)

To learn more about iExchange and request passwords or training, visit the WPS iExchange web portal on the WPS website.

HSM Web Portal for Rehabilitative Therapy Authorizations

The HSM Web portal is accessible via WPS iExchange. 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 Using the HSM Web Portal

- Increased rate of auto-approval
- Email alerts on case updates (if an email address is provided)
- Online status monitoring
- Immediate HSM feedback
- Medical records submission (if records are requested by HSM)
- Online printing of requests and letters
- Clinical resources for PT, OT, and ST providers

Using the HSM Portal

The WPS iExchange log in page provides a convenient link to the HSM portal. If you already have an account with HSM, you can use the same account to request services for WPS members. If you do not have an existing account, please contact HSM Provider Services at 1-800-432-3640, option 3, for assistance.

INTEGRATED CARE MANAGEMENT

Integrated Care Management (ICM) is a strategy to provide a member-centered approach for managing the health of a population. ICM is not confined to a disease; rather, it is a philosophy for maximizing the overall health and well-being of a population. We use our data, clinical expertise, and technology tools to identify those members who will benefit most from our ICM interventions. Then, we use available services to meet those members' needs at all points along the Care Continuum. The following graphically illustrates the Care Continuum:

The WPS ICM team seeks to meet members wherever they fall on the care continuum. The goal is to get members moving toward the healthy end of the range using the expertise of the care team which includes a nurse, health coach, data analyst, and physician.

Nurses: Members are paired with specific nurses so that each member has a familiar contact person at WPS. Nurses reach out to members and set up phone calls to evaluate the kind of help each member needs. Nurses can help educate members about health conditions and assist with benefit issues, such as prior authorizations for outpatient procedures and inpatient stays. Nurses can also collaborate with the member's PCP.

Health Coaches: Health coaches are specially trained to focus on member wellness and encourage healthy lifestyles. Health coaches can help members with exercise plans, healthier eating choices, stress reduction, and smoking cessation.

Data Analysts: Data analysts are specially trained to examine data and use sophisticated tools to assist our clinical staff in identifying members who appear to be good candidates for the ICM program.

Physicians: The ICM program is overseen by a clinical staff, including physicians, whose goal is to ensure that members are getting the help they need to manage their health in the most effective ways, and that the program is based on the latest evidence-based medicine.

Each member choosing to participate in the ICM program receives a customized experience based on claims information and the health information the member chooses to provide. All consultations between the members and the nurses and/or health coaches are confidential.

The ICM program integrates care management, disease management, wellness, and complex case management programs.

Great Beginnings Prenatal Program

Any WPS enrollee with a confirmed pregnancy is eligible to participate in Great Beginnings. The program offers:

- An initial assessment and precertification for the upcoming delivery
- Telephone access to an experienced maternal child nurse who will be an additional resource throughout the pregnancy
- Individual case management (at no additional cost to the enrollee) for any complications of the pregnancy such as diabetes, pre-term labor, high blood pressure, or multiple gestation (twins, triplets, etc.)
- Coordination of care with the enrollee's physician for any special services or supplies that may be required
- Educational materials

Contact ICM

To obtain more information about the ICM program, contact WPS Medical Management Department 1-800-333-5033.

UTILIZATION REVIEW

Medical necessity decision-making requires consistent application of utilization criteria which are explicit and evidence-based. WPS uses both nationally published and internally developed guidelines. Internal guidelines are approved by the Medical Policy Committee which meets quarterly. Final approval is by the Clinical Quality Management Committee. Nationally published and internally developed guidelines are reviewed annually or more frequently if significant changes in standards of care are identified.

Medical Necessity and Experimental/Investigational Determination Guidelines

- InterQual care management criteria
- Prest and Associates behavioral health criteria
- Internally developed medical policies and guidelines
- National Comprehensive Cancer Network (NCCN) guidelines
- UpToDate– an evidence-based decision support tool
- Internal clinical experts including the Senior Medical Director, Assistant Senior Medical Director, Physician Advisors, a Pharmacist, registered nurses, and behavioral health and physical medicine specialists
- Contracted external physician review organizations
- Apollo guidelines
- Centers for Medicare & Medicaid Services (CMS)

In the absence of a nationally published or internally developed guideline, guidelines of other insurers may be reviewed to gauge the level of evidence, and the degree of consensus, that exists to support the requested service. Proprietary guidelines may not be quoted without written permission of the guideline owner. Guidelines that are in the public domain may also be consulted, such as Medicare guidelines and Cochrane evaluations.

In certain situations, WPS will send a case to an outside specialist for review at the first level. WPS generally uses the Medical Review Institute of America to perform these specialty reviews.

Internally developed WPS Medical Affairs Policies and Procedures are available to providers and members on the WPS website without password protection. NCCN Treatment

Guidelines are available free to the public on the NCCN website upon registration. Medicare guidelines are available to the public on the CMS website.

Peer-to-Peer Review

A peer-to-peer discussion with a WPS physician reviewer or Medical Director is offered to the ordering provider upon denial of services which are determined to be not medically necessary or experimental or investigational. It is another opportunity to provide additional information pertinent to the denial decision.

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

The discussion will involve the requesting provider and a WPS physician medical director or a contracted physician reviewer. In pertinent cases it may involve a chiropractor, rehabilitation therapist, or a pharmacist.

If the decision for denial for services is not overturned, the next step is a grievance/appeal which must be requested by the member according to the directions given to him or her in the denial letter. This option and process will be discussed and offered during a peer-to-peer review if the decision for denial is upheld.

PEDIATRIC VISION MANAGEMENT

Due to the Affordable Care Act (ACA), vision benefits are changing for *some* WPS members. This primarily includes individuals who purchase their own insurance or work for small employers with fewer than 50 employees. The benefit is limited to pediatric vision care for those who are under age 19. If such a product is purchased, the benefits are as follows:

WPS will cover either prescription eyeglasses OR contact lenses.

Lenses: Coverage is limited to one pair of single vision, conventional bifocal, or conventional trifocal lenses per calendar year. Replacement lenses are not covered.

Frames: Coverage is limited to one pair of frames from a selection of covered frames per calendar year. Replacement frames are not covered.

Contact Lenses: Coverage is limited to six pairs of contact lenses from a selection of covered lenses every three months. Contact lenses are provided in lieu of eyeglasses.

Other lens options and treatments: Other lens options and treatments will only be covered if determined to be medically necessary and prior authorization is obtained.

A Prior Authorization is required for these services:

1. Contact lenses for the following conditions:
   - Keratoconus
   - Pathological myopia
   - Aphakia
   - Anisometropia
   - Aniseiknoia
   - Aniridia
   - Corneal disorders
   - Post-traumatic disorders
   - Irregular astigmatism

2. Low vision services including the following:
   - One (1) comprehensive low vision evaluation every five (5) years;
   - Low vision aids, including only the following:
     - Spectacles
     - Magnifiers
     - Telescopes
   - Follow-up care of four (4) visits in any five-year period

3. The following lens options and treatments;
   - Ultraviolet protective coating
   - Blended segment lenses
   - Intermediate vision lenses
   - Standard progressives
   - Premium progressives
   - Photochromic glass lenses
   - Plastic photosensitive lenses
   - Polarized lenses
   - Standard anti-reflective coating
   - Premium anti-reflective coating
   - Ultra anti-reflective coating
   - High index lenses

Effective 1/1/14, WPS has contracted with **Classic Optical Laboratories, Inc.**, to provide covered eyeglasses, eyeglass component parts, and contact lenses to WPS Members who have a vision hardware benefit.

A selection of frames can be viewed and purchased for display in your clinic by visiting classicoptical.com. This expense is not reimbursed by WPS. Please call Classic Optical Laboratories at 1-888-522-2020 for additional frame information.

Through the Classic Optical Laboratories website, providers can also place and track orders for covered eyeglasses, verify frame availability, and check changes to selection. When ordering online, only covered materials and frames may be ordered using Classic Optical's "SMART" ordering form.

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

- Choose the **New Providers Click Here** option on the Classic Optical website, and then complete the registration process.
- Call Classic Optical Laboratories, Inc., at 1-888-522-2020 during regular business hours (8 a.m.-6 p.m. CT, Monday through Friday).

Orders for **contact lens purchase** must be submitted via fax at 1-888-522-2022. Orders for eyeglasses may also be placed via fax.

Eyeglasses, eyeglass component parts, and contact lenses (in lieu of eyeglasses) that are not provided by the WPS contracted vendor will not be reimbursed by WPS without prior authorization. Providers may not 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 preadmission requirements stated in the member's benefit plan. However, if a member is admitted on an emergency basis, you 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 any request for care or treatment where the application of the time periods for making non-urgent care determinations could result in the following circumstances:

1. Seriously jeopardize the life, health, or safety of the member or others due to the member's psychological state, or
2. In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

PROVIDER CONTRACT PROVISIONS

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 conform to all terms of the PPO Agreement applicable to provider; and
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.

REVISIONS

Version	Date Revised
1.0	10/03/2013
1.1	03/20/2014
1.2	04/24/2014