WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION

UTILIZATION MANAGEMENT AND QUALITY MANAGEMENT (UM/QM) PROGRAM AND PROCEDURES

I. UTILIZATION MANAGEMENT (UM) PROGRAM AND PROCEDURES

Elective Admissions.

1. On behalf of the Covered Member, the Health Care Provider is required to prior authorize the member's elective Hospital inpatient admission with WPS at least three (3) business days prior to the date of admission.

2. Failure to prior authorize the admission with WPS in accordance with # 1, may result in a reduction of or no benefits payable for Covered Services.

3. WPS will conduct concurrent review of Hospital inpatient admissions.

4. WPS utilizes ***mcg*** Care Guidelines to evaluate appropriateness of the admission, length of stay and continued stay. ***Current medical policies are available on the provider tab of the WPS website.***

5. Integrated Care Coordinators (nurses) from WPS will contact the Hospital periodically throughout the Hospital stay to receive updates on the patient's condition, prognosis and discharge plans, as well as other relevant information.

6. Participating Provider or Hospital shall provide WPS with all required clinical information for UM efforts within twenty-four (24) hours or one (1) business day of the WPS request. For holidays and weekends, clinical information will be provided within two (2) business days. The information may be provided by phone, fax or via the iExchange provider portal.

7. If the WPS Integrated Care Coordinator (ICC) determines that a Hospital inpatient stay is not meeting criteria for continued stay, the ICC will refer the case to the WPS Medical Director for further review.

8. Denial of Benefits for a continued stay may only be rendered by a WPS Medical Director. Prior to such determination, the WPS ICC will make a good faith effort to obtain additional information or contact the attending Physician for further discussion of the case.

9. WPS will communicate any Benefit Denial for an admission or continued stay to the Hospital or attending physician via phone or fax at the time of the Denial, and confirm by letter within one (1) business day of the denial decision. The patient shall also be notified in writing within one (1) business day of the denial decision.

10. 10. In the event of a denial of Benefits for an admission or continued stay based on concurrent review, the Participating Provider or Hospital may appeal such a denial by advising WPS of its intent to appeal the denial and/or request to speak to the Medical Director. Provider/Hospital shall then furnish additional clinical documentation for the WPS medical staff to review.

11. For a retroactive review of a denial, Covered Member, Participating Provider or Hospital may file a written appeal to the WPS Customer Service Appeals / Grievance Department.

Emergency Admissions.

All of the above programs and procedures apply to emergency Hospital inpatient admissions, except that notification of the patient's admission shall be made to WPS within two (2) business days after the date of the patient's admission.

Outpatient Review.

1. WPS may conduct concurrent review of certain ambulatory procedures or diagnoses as required by Covered Member's Plan/Certificate of Coverage.

2. Prior authorization of selected procedures may be required by Covered Member's Plan/Certificateof Coverage or WPS Medical Policies.

3. WPS contracts with HSM, Inc. to conduct review of chiropractic and physical, occupational and speech therapy records to determine medical necessity of those services according to current standards of care.

II. PROCEDURES FOR HOME HEALTH CARE SERVICES

1. A Physician's order must be obtained in advance for Home Health Care, IV Therapy, Durable Medical Equipment (DME) and Respiratory Equipment prescribed for a Covered Member.

2. Please call the WPS MA Department at 1-800-333-5003 for prior authorization for any home health care IV therapy.

3. The WPS MA Intake staff will request the following demographic information: Covered Member/Patient Name; Subscriber Number; Date of Birth; Group Number; Desired Service or Medication, and Diagnosis.

4. The home care request is assigned to a WPS ICC. The ICC will return the call by the end of the day if the call is received prior to 12 noon, or by noon the next day if the call is after 12 noon.

5. If a referral to the Provider occurs after 4:30 p.m., on a holiday or weekend, the Provider should call WPS MA at 1-800-333-5003 and leave a message with the demographic information, and request that the ICC return the call within the next business day.

6. Visits made on a holiday and/or weekends must be Medically Necessary. The WPS ICC will review the verbal or written Health Care Services with the Provider within 72 hours of the visit.

7. The primary home care nurse following the case is responsible for the contact with the WPS ICC. Both parties will agree to the frequency of ongoing reports on a per case basis.

8. In the interest of continuity of care, the primary nurse will provide the ongoing patient assessments as above.

9. DME rental charges will apply toward the purchase price and will not exceed the purchase price.

10. A prior authorization is required for all DME greater than $250 per month rental or a $750 purchase price. Providers may fax information regarding the medical necessity of the equipment to (608) 226-4777; call with information to 800-333-5003; or obtain web-based authorization via iExchange.

NOTE: *Patient's Plan dictates coverage, such as length of home care visit, mileage coverage and sales tax.*

III. CLINICAL QUALITY MANAGEMENT PROGRAM QUALITY REVIEW ACTIVITIES

Goal: To foster continuous quality improvement in the delivery of Health Care Services to Covered Members through a collaborative effort between WPS and the Participating Provider.

Participating Provider's Responsibility/Process:

1. Provider will respond to the following surveys on a timely basis when requested: satisfaction surveys; access surveys; and service surveys.

2. In compliance with national accreditation standards, WPS may complete random on-site review of medical records for identified Covered Members to assess the quality of Health Care Services provided to them. WPS may request written documentation of such Health Care Services. Advance notice at a mutually agreeable time will be arranged.

3. Provider will assist with focus studies to provide objective assessment of processes and health / medical outcomes of Health Care Services, including HEDIS measures when requested.

4. In compliance with national accreditation standards, WPS may request the Participating Provider's cooperation with credentialing/contracting. WPS uses a systematic approach to assess qualifications of potential Providers through a review of relevant training, licensure, and certification to practice in a health care field.

5. WPS may request that the Participating Provider consider participation in a focus Continuous Quality Improvement (CQI) team.

WPS Continuous Quality Improvement Focus Areas.

1. Covered Member/Patient outcome studies
2. Physician and Covered Member surveys
3. Focus review
4. High volume or high-risk service reviews
5. Under- or over-utilization of Health Care Services
6. Continuity and coordination of Health Care Services
7. Standards for access to Health Care Services
8. Participating Provider credentialing
9. Physician profiling