

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. Covered Member (or health care provider on behalf of Covered Member) is required to notify WPS at least three (3) calendar days, or as soon as practical, prior to the date of the patient's elective Hospital inpatient admission.
2. Failure to notify WPS in accordance with paragraph 1 may result in a reduction of benefits payable for Covered Services.
3. WPS will conduct concurrent review of Hospital inpatient admissions; or if not practical, retrospective review will be done to determine Medical Necessity.
4. WPS utilizes *criteria such as* OptiCare Cert, Interqual Severity of Illness and Intensity of Service (ISI/IS) criteria or modified criteria, and HCIA length of stay guidelines as guides to evaluate appropriateness of admission, length of stay and continued stay. *Current criteria are available on the provider corner of the WPS website.*
5. Managed Care Coordinators 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 needed clinical information for UM efforts within twenty-four (24) hours or one business day of WPS' request. For holidays and weekend clinical information will be provided within two (2) business days. The information may be provided by phone or fax.
7. At any point that WPS Managed Care Coordinators determine that a Hospital inpatient stay is not meeting criteria for continued stay, the case will be referred to the WPS Medical Director / Physician Advisor for further evaluation.
8. Denial of Benefits for continued stay may only be made after physician review. Prior to such determination, the WPS Medical Affairs Department shall make a good faith effort to obtain additional information or contact the attending Physician for further discussion of the case.
9. Any denial of Benefits for an admission or continued stay based on concurrent review decisions shall be communicated by WPS at the time of the denial to the Hospital and attending physician by phone or fax and confirmed by letter within one business day of the decision to deny. The patient shall be notified in writing within one (1) business day of the decision to deny.
10. In the event of a denial of Benefits for an admission or continued stay based on concurrent review decisions, Participating Provider or Hospital may appeal such denial by advising WPS of its intent to appeal the denial and/or request to speak to the Medical Director. Hospital shall then furnish additional documentation for review by the WPS medical staff.

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

Emergency Admissions.

All of these 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. Preauthorization of selected procedures may be required by Covered Member's Plan/Certificate of Coverage.
3. WPS may conduct review of chiropractic records to determine medical necessity of services utilizing 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 and Respiratory Equipment prescribed for a Covered Member.
2. Please call WPS Value Care (VC) at 1-800-333-5003, and ask for Prescreen/Case Management in advance of any home health care IV therapy.
3. The WPS Prescreen Case Manager will request the demographic information identified in #4 below.
4. Covered Member/Patient Name, Subscriber Number, Date of Birth, Group Number, and Diagnosis.
5. A WPS Case Manager will be assigned the case. The WPS Case Manager 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.
6. If a referral to the Provider occurs after 4:30 p.m., on a holiday or weekend, the Provider should call WPS Value Care at 1-800-333-5003 and leave a message with demographic information and request that the Case Manager return the call within the next business day.
7. Visits made on a holiday and/or weekends must be Medically Necessary. Review of Health Care Services, verbally and/or written, will be done by the WPS Case Manager with the Provider within 72 hours of the visit.
8. Contact with WPS Value Care will be the responsibility of the primary nurse following the case. Frequency of the reports will be agreed to by both parties on a per case basis.
9. In the interest of continuity of care, ongoing patient assessments will be made by the primary nurse.

10. Durable medical equipment rental will be applicable toward the purchase price and will not exceed the purchase price.
11. For durable medical equipment greater than \$500 a preauthorization is recommended. 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 through I-EXCHANGE.

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. Assistance in responding on a timely basis to the following surveys may be requested: satisfaction surveys; access surveys; and service surveys.
2. In compliance with national accreditation standards, random on-site review of medical records of identified Covered Members to assess quality of Health Care Services provided to them. Written documentation of such Health Care Services may be requested. Advance notice at a mutually agreeable time will be arranged.
3. Assistance with focus studies to provide objective assessment of processes and health / medical outcomes of Health Care Services, *including HEDIS measures*, may be requested.
4. In compliance with national accreditation standards, WPS may be requesting the Participating Provider's cooperation with credentialing/contracting. This would be done using a systematic approach to assess qualifications of potential Provider 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