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Welcome

WPS Health Plan welcomes you as a partner

The WPS Health Plan Provider Manual is designed specifically for WPS Health Plan providers. It is supplied to you by WPS Health Plan (WPS) to promote a clear understanding of our policies and procedures, including provider services, prior authorization, claims, and eligibility.

This manual should be used as a reference guide. Its purpose is to answer some of the questions you may have regarding WPS operations.

As changes evolve, this manual is revised on a routine basis. WPS reserves the right to revise or alter the material and information detailed in this manual.

When accessing the Provider Manual, please refer to our website, wpshealth.com/healthplan, for the most current information.
About Us and Our History

About WPS Health Solutions

Wisconsin Physicians Service Insurance Corporation (WPS Health Solutions) is a nationally regarded benefits administrator for a variety of U.S. government programs and a leading not-for-profit health insurer in Wisconsin. WPS Health Solutions serves active-duty and retired military personnel, seniors, individuals, and families in Wisconsin, across the U.S., and around the world.

WPS Health Solutions has deep roots in Wisconsin, grounded in events that occurred in the mid-1940s. It was a time when many people, including soldiers returning from World War II, 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 helped Wisconsin residents cover the costs of health care. In 1946, the Medical Society established Wisconsin Physicians Service (WPS) to market and administer the plan. Over the years, WPS Health Solutions developed expertise that enabled the company to become a successful provider of administrative services for the U.S. government.

Today, Wisconsin Physicians Service Insurance Corporation uses “WPS Health Solutions” to refer to our entire enterprise. Within our enterprise, there are three divisions: WPS Government Health Administrators, WPS Military and Veterans Health, and WPS Health Insurance/WPS Health Plan/EPIC Specialty Benefits.

- WPS Military and Veterans Health serves millions of members of the U.S. military and their families through TRICARE and Veterans Affairs programs.
- WPS Health Insurance offers Preferred Provider Organization (PPO) health plans for individuals and groups, third-party administrator services, plus Medicare supplement plans and Medicare prescription drug plans for individuals who are eligible for Medicare.
- WPS Health Plan (formerly Arise Health Plan) offers Health Maintenance Organization (HMO) and Point-of-Service (POS) plans to the group and individual markets in eastern and north-central Wisconsin, plus third-party administrator services.
- EPIC Specialty Benefits, a leader in nonmedical group benefits and third-party administrator services since 1984, offers term life, disability, dental, vision, hospital indemnity, and voluntary benefits throughout the Midwest.

About WPS Health Plan

WPS Health Plan, Inc. (WPS Health Plan; formerly Arise Health Plan) is a fresh choice in a crowd of big, impersonal, national health insurance giants. WPS is committed to customers, easy to work with, and as transparent as possible, which helps customers always understand their benefits. Based in Green Bay, Wis., WPS Health Plan continues its tradition of Wisconsin-based service and is always looking for ways to make owning and using health insurance easier.

WPS Health Plan is a wholly owned subsidiary of Wisconsin Physicians Service Insurance Corporation and one of the brands under the umbrella of WPS Health Solutions.
Our Service Area

Throughout eastern Wisconsin, WPS Health Plan offers comprehensive and affordable health plans with a service area that covers most of the state. We understand how important it is for our customers to have access to great doctors. That’s why our customers get access to top-quality providers with a full range of health care services, striking a balance between choice and cost.

To ensure our customers get the best quality and value, we’ve selected providers with a strong commitment to health and wellness. Not all providers in our service area are participating. We include major providers in more than 50 Wisconsin counties as shown on the map below.

To see which networks and providers are included, please search our online provider directory. Visit wpshealth.com/healthplan, click on Find A Doctor, and choose WPS Health Plan to start your search. Our online directory is continually updated throughout the year, so when referring to colleagues outside of your office/health system, please verify network participation.
Contact WPS Health Plan
Website  wpshealth.com/healthplan

Provider Customer Service
Phone  888-711-1444
Fax  608-223-3639
Hours  Monday through Friday, 7:30 a.m.–5 p.m. CT

Log in to Your Provider Account for:
• Coverage verification
• Provider verification
• Questions regarding claim processing or payment
• Benefit and policy determination

Claims Filing Address:  WPS Health Plan
P.O. Box 21352
Eagan, MN 55121

Claim Correspondence Address (Questions on claim processing or payment):
WPS Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625

Electronic Data Interchange (EDI) Help Desk
Toll-Free  800-782-2680, option 1
Email  edi@wpsic.com
Web  wpshealth.com/resources/provider-resources/edi/index.shtml
Hours  Monday through Friday, 7:55 a.m.–4:30 p.m. CT

Contact the EDI Help Desk for:
• Questions about online registration
• How to log in
• Missing files
• Other technical concerns

Integrated Care Management
Phone  888-711-1444
Inpatient-only fax  608-226-4711
Prior authorization fax  608-226-4777

Contact Integrated Care Management for:
• Prior authorization
• Status of an authorization

Network Management
Phone  920-617-6325 or 888-711-1444, ext. 76325
Fax  920-490-6923
Email  GBNetworkDevelopmentDept@wpsic.com

Call Network Management for:
• Provider additions, terminations, and changes
• Fee schedule questions
• Assistance with provider issues
• Provider directory/website listings
Provider Relations

Phone  920-490-6903
Fax   608-977-9939

Contact the Provider Relations team for:
• Fee schedule inquiries
• Provider contracts
• Reimbursement policies

Northwestern/North-Central Wisconsin
Lukas Carlson, Provider Network Coordinator
608-977-6770
Lukas.Carlson@wpsic.com

Lori Olivares, Provider Contract Manager
608-977-6643
Lori.Olivares@wpsic.com

Northeastern Wisconsin
Tiffany Kollar, Provider Network Coordinator
920-490-6967
Tiffany.Kollar@wpsic.com

Chris Fredericks, Provider Contract Manager
920-617-6305
Chris.Fredericks@wpsic.com

Mary Osmond, Provider Contract Manager
920-617-6303
Mary.Osmond@wpsic.com

Southwestern/South-Central Wisconsin
Lukas Carlson, Provider Network Coordinator
608-977-6770
Lukas.Carlson@wpsic.com

Jayne Thompson, Provider Contract Manager
608-977-6688
Jayne.Thompson@wpsic.com

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

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

Provider Credentialing

Credentialing Manager
920-490-6952

Senior Credentialing Specialist
Phone  608-977-6613
Fax   920-490-6955 or 608-221-5479
Email  ProviderCredentialing@wpsic.com

Contact Provider Credentialing with questions concerning:
• Initial credentialing
• Re-credentialing

Independent Chiropractors

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

Main Phone  952-225-5732
Toll-Free     800-432-3640
Fax          888-656-1913

Please contact Magellan Healthcare directly regarding contracts and/or credentialing.
Product Overview
WPS Health Plan offers a broad range of insurance and employee benefit products to meet the needs of our group and individual customers, from traditional Health Maintenance Organization (HMO) and Point-of-Service (POS) plans to self-funded administration and consumer-driven options.

Individual and Family Plans
Available plan options include HMO plans with great value and POS plans that give customers added coverage for health care services received out of network at a reduced benefit level, as well as consumer-driven high-deductible health plans (HDHPs) that can be paired with a Health Savings Account (HSA).

Small Group Plans
WPS Health Plan offers carefully designed small group health plans to employers with 2–50 employees. Plan options include HMO plans with great value and POS plans that give customers added coverage for health care services received out of network at a reduced benefit level, as well as consumer-driven high-deductible health plans (HDHPs) that can be paired with a Health Savings Account (HSA).

Large Group Plans
WPS Health Plan offers a variety of large group health plans to employers with 51 or more employees. Plan options include HMO plans with great value and POS plans that give customers added coverage for health care services received out of network at a reduced benefit level, as well as consumer-driven high-deductible health plans (HDHPs) that can be paired with a Health Savings Account (HSA). Plan features include $0 copay, deductible, or coinsurance on preventive care; $0 copay on select preventive drugs that target common conditions, such as high blood pressure, cholesterol, heart conditions, and asthma; and fitness program reimbursement.

Self-funded Group Plans/Administrative Services Only (ASO)—WPS Administrators
WPS Health Plan contracts with employers or other group entities to provide claim administrative services to self-funded health plans under an ASO arrangement. This self-funded business is administered under the name WPS Health Plan Administrators. An employer can hire a third party, like WPS Health Plan Administrators, to deliver claim administrative services for the employer. These services typically include health claims processing, billing, and Integrated Care Management. The employer bears the risk for health care expenses under a self-funded plan.

What does this mean for our contracted providers? ID cards for this business will use WPS Health Plan Administrators’ name and logo. Claims can be remitted to the same address used for WPS Health Plan.

For plans administered under a self-funded arrangement, no withholding will be taken if the contract includes withhold language.

1Preventive care services and preventive drugs are limited to the services and prescriptions ranked A or B by the U.S. Preventive Services Task Force.
Customer Identification (ID) Cards

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

Provider Contracting

Participation in the WPS Health Plan (formerly Arise Health Plan) provider network(s) requires a participating provider agreement. WPS Health Plan and WPS Health Insurance are separate business entities. A signed agreement with one does not secure participation with the other.

Non-Contracted Providers

If you’re interested in participating in the WPS Health Plan provider network, please visit the How to Become an WPS Health Plan Provider section of our website*, or send a letter of intent to:

WPS Health Plan  
P.O. Box 11625  
Green Bay, WI 54307-1625

The letter of intent should include the following information:

- Clinic/facility name, address, and phone number
- Tax Identification Number
- Specialty
- Unique services or treatments provided
- Full practitioner roster by location
- If you are treating any of our existing customers
- Contact name and number

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

Contracted Providers: Practitioner Roster, Facility, and Other Provider Changes

To notify us of roster and location additions, deletions, or changes, please complete the Practitioner Datasheet Form or Facility Datasheet Form found on the Provider Resources section of our website under Forms and Documents, or call 920-617-6325 to request an up-to-date copy.

If you leave your current practice and open or join a new practice, it’s possible that your new practice does not have a contractual agreement with WPS. Contact the appropriate Provider Relations staff identified under the Contact WPS Information section of this manual to verify participation status.
Provider/Patient Relationships

Providers may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Compliance with Program/Provider Manual

WPS Health Plan providers agree to participate, cooperate, and comply with materials outlined in the Provider Manual, including quality improvement activities. Participating providers shall not be entitled to reimbursement from insurer or covered customer for covered services, even those that are deemed to be medically necessary pursuant to the covered customer’s health plan, when such services are not provided in compliance with the program.

WPS Health Plan providers agree to allow WPS to use performance data, such as, but not limited to, Wisconsin Collaborative for Healthcare Quality (WCHQ), Wisconsin Health Information Organization (WHIO), etc., for analysis and peer comparison. Such data may be used to develop and evaluate quality improvement activities. Results may be shared via public reporting methods and other methods, including, but not limited to, web-based tools.

Subcontracts For Covered Services

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

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

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

Primary Care Access Model

Primary Care Practitioners (PCP) are the core of WPS Health Plan. The objective of our Primary Care Access Model is to guide customers into an ongoing relationship with a PCP. The PCP is the provider responsible for coordinating the medical care for each customer.

We define PCPs as:

• Family practice
• General practice
• Internal medicine
• Obstetrics/gynecology
• Pediatrics

We believe this PCP model provides customers with medical services within a time frame that allows safe treatment of emergency and urgent conditions and maintains effective preventive health care practices.

A list of PCPs is available on our website through Find A Doctor or our provider directory. It is important for customers to always identify themselves as WPS Health Plan customers whenever they make an appointment with a provider.

WPS Health Plan customers have reasonable access to care and services within the WPS Health Plan service area with respect to geographic location, hours of operation, and waiting times.

WPS Health Plan contracts with a sufficient number of PCPs, specialists, and other health care providers who are in the geographic service area to meet the medical needs of our plan customers.
Appointment Scheduling Guidelines

Customer requests appointment for care. Clinic receptionist, nurse, or specified person determines type of care (if unable to determine the type of care or if patient/customer has additional concerns, the situation is referred to the nurse or physician).

- Preventive Care: Involves asymptomatic patient/customer; visit is for wellness, annual exam, scheduled immunization, or other non-illness/injury-related issue.
- Routine Problem: Involves patient/customer with stable, non-urgent symptoms or conditions that: are not likely to change in the next 48 hours; do not cause concern about an illness or injury; do not interfere with normal daily activities.
- Urgent Problem: Involves patient/customer with active symptoms or conditions that: are likely to escalate in the next 48 hours; cause concern about an illness or injury; interfere with normal daily activities.
- Emergent Problem: Involves severe active symptoms or conditions that are life-threatening; will become life-threatening if not treated; require medical care immediately or within the next two hours.

Clinic receptionist schedules appointment and strives to meet the following standards:

<table>
<thead>
<tr>
<th>Type of Medical Care Appointment</th>
<th>Preventive Care</th>
<th>Routine Problem</th>
<th>Urgent Problem</th>
<th>Emergent Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max. Time from Patient Request to Appointment Date</td>
<td>30 days</td>
<td>7 days</td>
<td>Same-day access</td>
<td>Immediate access</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Behavioral Care Appointment</th>
<th>Routine Care</th>
<th>Urgent Care</th>
<th>Non-Life-Threatening Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max. Time from Patient Request to Appointment Date</td>
<td>10 days</td>
<td>Within 48 hours</td>
<td>6 hours</td>
</tr>
</tbody>
</table>

A consult is an appointment made at the request of the PCP. The clinic schedules a consult appointment based on the same guidelines set forth for Preventive Care, Routine Problem, and Urgent Problem, as defined above.

If the PCP or consulting physician cannot see the patient within the time frame indicated by the clinic and WPS Health Plan guidelines, an appointment will be offered with an alternate physician/same site or, if unavailable, with an alternate physician/different WPS Health Plan site. The patient may decline the alternate arrangement and accept a delayed appointment with the PCP.
Credentialing

WPS Health Plan will credential practitioners who have an independent relationship with WPS Health Plan. An independent relationship exists when WPS Health Plan selects and directs its customers 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 (recredentialing) is conducted at least every three years.

Doctors
- Medicine (MD)
- Osteopathic medicine (DO)
- Podiatric medicine (DPM)
- Chiropractic (DC)
- Optometry (OD)
- Doctors of dental science (DDS); doctors of medical dentistry (DMD) who provide care under the medical benefit program

Behavioral Health Care Practitioners
- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or Master’s level Clinical Psychologists (PhD, PsyD)
- Master’s level clinical nurse specialists or psychiatric nurse practitioners (NP, APNP)
- Physician Assistants (PA, PAC)
- 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 (MA, MS, MSE, MSW)
- Licensed Behavioral 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, PAC)
- Audiologists (AuD)

Other allied health professionals who have an independent relationship with us and are not part of an organization or group of practitioners:
- Covering practitioners (Locum Tenens) who provide services for a period of time longer than six (6) months.
- Practitioners who are hospital-based, but see customers outside of the inpatient hospital setting or outside freestanding, ambulatory facilities as a result of their independent relationship with the plan (pain medicine, radiation oncology).
- Rental networks that are part of the WPS Health Plan network and have customers who reside in the rental network area OR are specifically for out-of-area care and customers may see only those practitioners or are given an incentive to see rental network practitioners.
- Telehealth practitioners who provide care to customers under WPS Health Plan medical benefits.

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

**During the credentialing process**

- You may request, in writing, all application and credentialing verification policies and procedures.
- You have the right to review information submitted to support your credentialing application.
- 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 be given the opportunity to submit updated/additional documentation or corrections.
- Notification of the Credentials Committee decision regarding your application will be sent via written letter promptly after the meeting at which your application is presented.

*Note: Approval of your credentialing application is not indicative of contract effective date.*

Contact the Network Development Department at 920-617-6325 or email GBNetworkDevelopmentDept@wpsic.com for your official effective date.

**Organizational Provider Credentialing**

WPS Health Plan conducts a pre-contractual assessment of each organizational provider that it is contracted with, and an ongoing assessment at least every three years.

**Organizational providers include:**

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Hospices
- Freestanding surgical centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting

**WPS Health Plan shall confirm that the organizational provider:**

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

For questions, contact the Credentialing Department at:

WPS Health Plan  
P.O. Box 11625  
Green Bay, WI 54307-1625  
Phone: 920-490-6952 or 608-977-6613  
Fax: 920-490-6955 or 608-221-5479  
Email: ProviderCredentialing@wpsic.com
**Integrated Care Management**

The Integrated Care Management (ICM) Program is designed to monitor the appropriateness, medical necessity, and benefit coverage of services for pre-service care, concurrent review, and post-service care delivered to WPS Health Plan customers.

The WPS Health Plan ICM team developed the program in collaboration with WPS Health Plan contracted health care providers. The strategy of our ICM Program is to promote optimal practice accounting for the structure of the local delivery systems. All components of the program comply with federal and state regulations and strive to meet the nationally recognized utilization standards of the National Committee for Quality Assurance (NCQA). The program is designed to make utilization decisions affecting the health care of customers in a fair, impartial, and consistent manner. The management of services focuses on the ongoing monitoring and evaluation of medical necessity, the appropriate level of care, the place of service, and availability of resources and benefits, while ensuring confidentiality of personal health information for all customers. The primary goals of the ICM Program are to oversee and ensure the quality of relevant care while promoting appropriate utilization of medical services and plan resources.

**Objectives of the Integrated Care Management Program**

*Provide a structured process to continually monitor and evaluate the delivery of health care and services to our customers by:*

- Establishing system-wide health management processes across the continuum of care.
- Ensuring health care services are coordinated, timely, medically effective, and efficient.
- Establishing a process for provider feedback regarding utilization.
- Monitoring indicators to detect possible under- and over-utilization of services.
- Auditing of denial decision timeliness and consistency.
- Conducting inter-reviewer reliability audits of all Integrated Care Managers and the Medical Directors.

*Improve clinical outcomes through:*

- System-wide collaboration to identify, develop, and implement clinical practice guidelines and programs, which address key health care needs of the customers.
- Implementation of clear, consistent ICM requirements and key indicators of success.
- Implementation of Behavioral Health management processes.
- Documentation and evaluation of patterns of resource utilization, including under- and over-utilization of services and implementation of actions for improvement as appropriate.
- Collaboration with the Quality Improvement (QI) Committee/department, Medical Director, and Manager of Integrated Care Management to assess and implement actions to improve continuity and coordination of care.

*Improve practitioner and customer satisfaction by:*

- Assessing practitioner and customer satisfaction with ICM policies and procedures.
- Promoting appropriate utilization of WPS Health Plan resources through efficiency of service.

*Follow established quality standards by:*

- Complying with NCQA standards for the accreditation of Managed Care Organizations.
- Measuring program performance in accordance with the Healthcare Effectiveness Data and Information Set (HEDIS) specifications.
The scope of the ICM Program consists of the following components:

- Affirmative Statement on Incentives
- Behavioral Health Management Program
- Care Coordination Program
- Chiropractic Care Management Program
- Complex Care Management Program
- Concurrent Review Decisions
- Emergency Services
- Grievances and Appeals
- Health Care Informatics
- Kidney Resource Service Program
- Neonatal Program
- Oncology Program
- Pharmacy and Specialty Drug Management Program
- Population Health Management
- Post-Service Determinations
- Primary Care Model of Care
- Prior Authorization Determination of Medical Services
- Radiology Benefit Management Program
- Satisfaction with the Utilization Management Process
- Technology Assessment
- Transition of Care Program

The following resources/tools support the ICM Program:

- Clinical Experts
- Clinical Practice Guidelines
- Conference/Seminars
- Definitions from the Certificate of Coverage
- External Review
- Literature
- Nationally published and locally developed Utilization Management Criteria
- Policies and Procedures

The ICM Department collects data on practitioner satisfaction with the Utilization Management (UM) process and reports this information to the Quality Improvement (QI) Committee for review and action, as they deem necessary.
Integrated Care Management Program

WPS Health Plan operates under a Primary Care model of health care. The Primary Care model provides high-quality health care by increasing opportunities for continuity of care; coordinating care among multiple providers; and effectively using the services of PCPs, specialty physicians, and other providers.

- WPS Health Plan customers must select a PCP upon enrollment in the Health Plan.
- PCPs may practice in the following specialties: Family Practice, Pediatrics, General Practice, Internal Medicine, or Obstetrics/Gynecology.
- Customers have direct access to participating PCPs and specialists.
- Specialists may refer to another specialist upon concurrence with the customer’s PCP.
  - Specialists who see a customer through referral are accountable for communicating the results of the consultation and recommend treatment to the customer’s PCP.
  - Specialists performing a procedure or providing a service that requires a prior authorization are responsible for notifying WPS Health Plan and discussing the customer’s care with the customer’s PCP.
  - When referring to a non-participating provider and tertiary care specialist/facility, the participating PCP or specialist must submit a written prior authorization request to WPS Health Plan prior to services being rendered.
  - Based on the medical complexity of services, we expect participating providers to follow prior authorization/referral guidelines.
  - We encourage customers to verify that their provider requested prior authorization and WPS Health Plan approved the request.
- The PCP is responsible for assessing, directing, and coordinating the customer’s need for specialty care.

The ICM department maintains and revises the ICM program. The Quality Improvement (QI) Committee reviews and approves the program annually.

Medical Directors are responsible for the key aspects of the ICM program, such as setting policies, reviewing cases, and participating on a variety of ICM committees and the Quality Improvement Committee. The Medical Directors oversee the inpatient and ambulatory utilization management programs, and the pharmacy benefit management program. Medical Directors make the final decision for all medical necessity denial decisions for inpatient, concurrent, pre-service, and post-service care.

ICM activities and initiatives are coordinated within the framework of the QI Program. A Medical Director is the Chair of the QI Committee.

The Medical Directors may consult with an appropriate board-certified specialist if a medical necessity review is outside of the Medical Directors’ scope of expertise.

WPS Health Plan has an active community psychiatrist involved in the Behavioral Health Program. Their role is to oversee and provide professional expertise to continually improve the Behavioral Health Program. Medical Directors consult with this practitioner on an as-needed basis regarding behavioral health issues/reviews.

Integrated Care Management Confidentiality

Customer health information that is identifiable, including medical records, claims, benefits, and administrative data, obtained in connection with the performance of duties in utilization management, shall not be revealed or disclosed in any manner or under any circumstance, except to a customer’s attending physician.

Information required to study and evaluate the quality of care, and/or policies or services focused on customers, shall be made available only to the persons directly involved in presenting, reviewing, evaluating, or acting upon the information.

Program descriptions, manuals, forms, and all related documentation are considered proprietary business information, and shall be treated as confidential.
Tools And Resources

Utilization Review Criteria

Medical necessity decision-making requires the consistent application of utilization criteria. WPS Health Plan uses both nationally published and locally developed criteria with input from WPS Health Plan practitioners. The Medical Policy Committee reviews criteria for appropriateness and makes recommendations for approval to the Quality Improvement (QI) Committee. The QI Committee makes the final decision to approve criteria for use. We review and update decision-making criteria annually or more frequently if there are significant changes in standards of care.

We apply criteria consistently to medical necessity decisions, and in a manner that is responsive to individual customer needs and the characteristics of the local delivery system. At least annually, WPS Health Plan evaluates the consistency with which Integrated Care Managers and the Medical Director apply the criteria when making decisions. We develop a corrective action plan if significant variation is found.

WPS Health Plan uses the following criteria, which include, but are not limited to:

- Cochrane Library
- Council on Chiropractic Guidelines and Practice Parameters (CCGPP)
- Hayes Medical Technology Directory
- Information from appropriate government regulatory bodies (e.g., Centers for Medicare & Medicaid Services (CMS), Food & Drug Administration (FDA), U.S. Department of Health & Human Services)
- MCG Care Guidelines
- Medical Management Medical Policy
- National Comprehensive Cancer Network (NCCN)
- National Guidelines Clearinghouse
- National Imaging Associates Clinical Guidelines
- National Institutes of Health
- National Library of Medicine Search
- PubMed (Medicine)
- Specialty Society guidelines and standards (e.g., American Academy of Pediatrics, American College of Physicians, American Cancer Society, American Medical Association)
- United States Preventive Services Task Force (USPSTF): preventive services only
- UpToDate consensus-based vendor resource

WPS Health Plan practitioners/providers may review the ICM criteria. We provide a copy of specific criteria used for decision-making to any WPS Health Plan practitioner upon request. This copy is for the practitioner’s own use and may not be released to others without permission from WPS Health Plan. We inform WPS Health Plan practitioners how to request criteria during practitioner orientation and in the provider newsletter.

The Medical Director or a designee will attempt to contact the attending practitioner prior to making an inpatient medical necessity denial. The Medical Director’s phone number is provided to the ordering practitioner when a medical necessity denial is made for outpatient care.

ICM Policies/Procedures

Policies are statements that define how WPS Health Plan intends to administer its ICM program. The QI Committee reviews all ICM policies. Each department is responsible for development of procedures for functions within its responsibility.
Clinical Experts

In addition to the Medical Director, the ICM team has access to clinical experts through WPS Health Plan’s practitioner panel, many of whom are board-certified and participate on various committees at WPS. WPS Health Plan also purchases a variety of expert services through external vendors. Examples of expert vendors used are:

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

The Medical Director or designee consults with board-certified practitioners, when appropriate, to accommodate the medical necessity review process. WPS Health Plan also has access to external review agencies that employ board-certified practitioners for case review as noted above.

Clinical Practice Guidelines

Clinical Practice Guidelines are designed to assist physicians by providing an analytical framework for the evaluation and treatment of patients with specific clinical circumstances. They are not intended to replace professional judgment or to establish a protocol for patients with a particular condition. A guideline will rarely establish the only approach to a problem. Practice guidelines have a sound scientific basis, such as clinical literature and expert consensus. The selected guidelines are from nationally recognized organizations and have been reviewed by Advisory Committees.

Practice guidelines are not intended to determine plan benefits and do not reflect coverage. Benefit coverage varies by plan and should be verified prior to services being rendered.

Guidelines are helpful in demonstrating the quality of care we provide to those who purchase our services.

You may easily access the Clinical Practice Guidelines adopted by WPS Health Plan by visiting the Provider Resources Support and Education section of our website. Another valuable resource for accessing nationally recognized and supported Clinical Practice Guidelines is the National Guideline Clearinghouse produced by the Agency for Healthcare Research and Quality (AHRQ). This site is available at guideline.gov/index.
Medical Record Requirements

WPS Health Plan has adopted the NCQA (National Committee for Quality Assurance) medical record documentation guidelines, which are designed to provide consistent, current, and complete information regarding the care of our customers. The medical record documentation guidelines include the following requirements:

- Patient's name or ID number on each page.
- Patient’s demographic information to include the home address, primary and secondary phone numbers, and employer and marital statuses.
- A problem list to indicate significant illnesses/medical conditions.
- Documentation of any known anaphylactic reaction and allergic trigger. All medication allergies and adverse reactions or documentation of no known allergies.
- A medication list.
- An immunization record if primary care.
- A patient history record to include medical history, surgical history, and social history.
- An organized medical record-keeping system as evidenced by easily identifiable, retrievable, individualized records. All entries must be dated and contain the author’s identification. Author’s identification may be a handwritten signature, unique electronic identifier, or initials.
- Documentation of clinical findings and evaluation for each visit. Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- A written medical record policy that addresses the ease of retrieval, timeliness of completion, and release and retention of medical records.
- To protect the confidentiality of medical records and guard against unauthorized disclosure of patient information, provider practices will have written policies/procedures that address confidentiality and storage of medical records in an area not accessible to the public.

Information filed in medical records includes, but is not limited to:

- All services provided directly by a PCP.
- All ancillary services and diagnostic tests ordered by a practitioner.
- All diagnostic and therapeutic services for which a customer has been referred by a practitioner, such as:
  - Home health nursing reports
  - Specialist reports
  - Hospital discharge reports
  - Physical therapy reports

The WPS Health Plan performance goal for participating practitioners and physicians is 90–100%.
Medical Policy Guidelines

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

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

Practitioners and other providers may obtain the Medical Policy guidelines used for making medical coverage determinations for a WPS Health Plan customer under their care. We base the Medical Policy guidelines on sound medical and clinical evidence with the involvement of appropriate medical specialists.

If you receive a determination and would like to review the medical policy guidelines used in that determination, you may contact us. To obtain medical policy guidelines for a specific subject through the Integrated Care Management (ICM) Department, please submit your request via phone, fax, or in writing to:

WPS Health Plan  
Attn: Integrated Care Management Department  
P.O. Box 11625  
Green Bay, WI 54307-1625  
Phone: 888-711-1444  
Fax: 608-327-6300

Note: If applicable, please include the customer name and number along with the subject (procedure/service/treatment) for which you are requesting the medical policy guidelines.

The medical policy guidelines are an informational resource and not an authorization, an explanation of benefits, or a contract to provide benefits. By following the medical policy guidelines, payment of health insurance benefits is not guaranteed.

Receipt of benefits is subject to satisfaction of all terms and conditions of the customer’s contract in effect at the time services are rendered. Medical technology is constantly changing, and we reserve the right to review and update our medical policy guidelines as necessary.

If you have comments or suggestions regarding a guideline, please submit in writing to:

WPS Health Plan  
Attn: Medical Policy Committee  
P.O. Box 11625  
Green Bay, WI 54307-1625  
Email: medical.policies@wpsic.com
Prior Authorization

What is a prior authorization?
Prior authorization is the process of receiving written approval from WPS Health Plan for services or products prior to being rendered. The provider requests and submits the prior authorization. Services are still subject to all plan provisions including, but not limited to, medical necessity and plan exclusions.

When is prior authorization needed?
Prior authorization is required for specialized services under our HMO and POS health plans. Please refer to the Prior Authorization section of our website to verify prior authorization requirements. Prior authorization is also required under our HMO plans when customers are seeking care from or being referred to non-participating providers and tertiary care specialists/facilities.

A prior authorization is not required for:
- Services performed by a participating provider, including a participating provider who specializes in obstetrics or gynecology, except for those services on the Prior Authorization List
- Emergency care or urgent care at an emergency or urgent care facility

Prior authorization process:
Based on the medical complexity of services, we expect participating providers to follow prior authorization guidelines.

If a prior authorization request is not submitted when appropriate, the service(s) will be denied. Providers may not bill a WPS Health Plan customer for services that have been denied by insurance and thereby rendered non-covered services because of (a) provider’s failure to follow the Program or (b) insurer’s determination that such services are not medically necessary pursuant to the WPS Health Plan customer’s health benefit plan. Providers may collect fees for services that are not covered services when the provider delivers such services on a “fee-for-service” basis with the customer’s prior, written acknowledgment and consent.

We encourage customers to verify prior authorization is requested by their provider and approved by WPS Health Plan.

- Providers should verify customer’s eligibility and benefits through the Provider Portal or by calling Customer Service at 888-711-1444.

- Providers should enter the prior authorization request, along with clinical information, in iExchange or via fax.
- Customers should review their health plan for specific authorization requirements, excluded services/treatments, and referral requirements.

Services that are exclusions of the customer’s health plan or listed on the Non-Covered Services and Procedures Medical Policy are not typically prior authorized. Services on this list are not covered so we don’t advise providers to submit prior authorization.

Prior authorization is required for most inpatient admissions:
Different standards apply depending on whether the admission is elective or acute.

- Elective admissions: Providers must submit a prior authorization request a minimum of three days prior to an elective (nonemergency) hospital admission or admission to a residential treatment program for treatment of alcoholism, drug abuse, or nervous or mental disorders.
- Acute admissions: The facility must notify WPS Health Plan within two days of an acute (direct or emergency) admission. Notification may be provided in writing or by calling the phone number located on the customer ID card or by calling Customer Service.

Providers should submit clinical information to support the admission. Information requested for concurrent review should be sent within 24 hours of our request.

Inpatient admissions include a customer’s admission to:
- Inpatient hospital
- Hospice inpatient facility
- Inpatient rehabilitation facility
- Skilled nursing facility, when Medicare is not primary
- Inpatient and residential facility for Behavioral Health Services
Prior Authorization Special Programs

Radiology Benefit Management

WPS Health Plan contracts with National Imaging Associates, Inc. (NIA Magellan Health (magellanhealth.com), an accredited leader in the management of outpatient radiology benefits, to review high-tech imaging requests. This program uses evidence-based guidelines for decisions.

Procedures requiring prior authorization:

- CT Scan
- MRI/MRA/MRS
- Nuclear Cardiology
- PET Scan

A separate authorization is required for each procedure ordered.

Note: Inpatient and emergency department imaging studies do not require prior authorization.

Prior authorization process:

- Visit RadMD.com or call 877-642-0922.
- The ordering provider submits the clinical information to NIA Magellan.
- NIA Magellan uses evidence-based criteria to review relevant information.
- Each ordered procedure requires a separate authorization. Procedures without proper authorization will not be reimbursed, and the customer cannot be balance billed as indicated in your provider agreement. The ordering provider may request a peer-to-peer discussion with a physician reviewer.

Rehabilitative Therapy Authorizations

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

Benefits of Magellan Healthcare Portal

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

Using the Magellan Healthcare Portal

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

Based on the Affordable Care Act (ACA), a pediatric vision care benefit is offered on individual and small group plans to customers who are under age 19. Please contact Customer Service for specific coverage information and prior authorization guidelines.

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

A selection of frames can be viewed and purchased for display at [ClassicOptical.com](http://ClassicOptical.com). Through the Classic Optical Laboratories website, providers can place and track orders for covered eyeglasses, verify frame availability, and make changes to selection. When ordering online, Classic Optical’s order form will only allow covered materials and frames.

To access these online options, please sign in with your Classic Optical username and password. If you are a new online customer, please contact Classic Optical’s customer service department at 888-522-2020 to obtain a username and password.

Eyeglasses and eyeglass component parts not provided by the WPS Health Plan contracted vendor will not be reimbursed by WPS without prior authorization. Providers cannot bill the customer without prior written acknowledgment and consent of the customer.
**Prior Authorization Submission**

**iExchange® Web Portal**

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

We strongly recommend providers submit prior authorization requests via the secure iExchange web portal. We offer telephonic training to assist your staff so they can be prepared for future submissions of cases.

**Benefits of iExchange**

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

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

**Enroll in iExchange**

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

- **Online:** Register by using the [Register for iExchange](#) link on our website.
- **Email:** iExchange@wpsic.com
- **Phone:** 800-333-5003 and ask to speak with an iExchange representative

To learn more about iExchange and access training tutorials, visit our iExchange web page.

**Paper Submissions**

A printable [Prior Authorization Form](#) can be found on our website under the Provider Resources Forms and Documents section of our website. Complete the form in its entirety and submit to the address or fax number listed on the form. This form also serves as a Referral Request form when requesting an out-of-network referral. Complete the form in its entirety and submit to the address or fax number listed on the form.
Prior Authorization Determination

The Integrated Care Management (ICM) Program requires prior authorization (PA) for all services referred to inpatient facilities, non-participating practitioners/providers, tertiary care specialist/facility and providers, and for other select services. We review these services for customer eligibility, medical necessity, potential redirection to an appropriate participating practitioner/provider, benefit coverage, and/or coordination of care/services.

Review Process

Providers submit requests online through iExchange (preferred method) or via fax, phone, or mail.

Then, the ICM team:

- Obtains all data and relevant information, including, but not limited to, medical records and communications with practitioners or other consultants.
- Uses Utilization Management (UM) criteria to review relevant information as described in the resources/tools section.
- Reviews inpatient facility care, such as acute, rehabilitation, and/or skilled nursing care, prior to or within 24 business hours of admission, then concurrently according to accepted criteria and guidelines.
- Provides non-urgent PA approval determinations to practitioners and customers via verbal, written, or electronic notification within 15 calendar days of the request. We provide non-urgent PA denial determinations within 15 calendar days of the request via written or electronic notification.
- Provides urgent PA approval determinations and denial determinations to practitioners and/or customers via verbal, written, or electronic notification within 72 hours of the request.
- Sends PA approval determination letters for select services and all denial determinations to the customer, the PCP (if applicable), the rendering practitioner, and the facility, if appropriate.
- Submits determination for review by the Medical Director, who renders a determination for all potential medical necessity denials.
- Attempts to contact the attending practitioner prior to making an acute inpatient medical necessity denial.

All written denial determination notifications:

- Include the specific reason for the denial.
- Refer to the benefit provision, guideline, protocol, or other similar criterion used for the denial decision.
- Offer to provide a copy of the actual benefit provision, guideline, diagnosis/treatment codes, protocol, or other similar criterion on which the denial decision was based—upon request.
- Describe appeal/grievance rights, including the right to submit written comments, documentation, or other information relevant to the appeal/grievance.
- Explain the appeal/grievance process, including the right to customer representation, and time frames for deciding appeals/grievances.
- Describe the expedited appeal/grievance process for urgent prior authorization or urgent concurrent denials.
- Notify that an expedited external review can occur concurrently with the internal appeal process for urgent care and ongoing treatment.
- Explain the external review process.
- Include contact information for language assistance.
Concurrent Review Decisions

Concurrent review decisions are reviews for the extension of previously approved, ongoing care. This includes the review of inpatient care as it is occurring or ongoing ambulatory care. When requesting an extension of care, it is important to include documentation that supports the medical necessity of the services in question.

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

Concurrent Review Process

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

Post-Service Determination

Post-service reviews are only performed in instances with extenuating circumstances.

Post-Service Process

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

Peer-To-Peer Review

We offer a peer-to-peer discussion between a WPS Health Plan physician reviewer or Medical Director with the ordering provider for the denial of services that we determine to be not medically necessary or experimental, investigational, and unproven on prior authorization and concurrent reviews. It’s another opportunity to provide additional information relevant to the denial decision.

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

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

If the decision to deny for services is upheld, the next step is a grievance, which the customer may request according to the directions provided in the denial letter.
Case Management

Case Management provides a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a customer’s health needs. We use communications and available resources to promote high-quality, cost-effective outcomes.

We select customers for case management based on criteria that address various demographics, including, but not limited to, age, psychosocial and economic status, support systems, diagnoses, and/or complexity of the treatment plan.

We identify cases through utilization reports, health promotion activities, claim activity reports, complicated inpatient admissions, prior authorizations, and practitioner or customer referrals for case management.

We conduct case management in collaboration with the practitioner to support the practitioner/customer relationship, and promote adherence to an established treatment plan. We notify customers of their selection for case management.

Complex Case Management Program

Complex Case Management (CCM) is the coordination of care and services provided to customers who experienced a critical event; have a diagnosis that requires the extensive use of resources; or require assistance in navigating the system to receive the appropriate delivery of care and services.

Evidence used to develop the CCM Program: We developed the CCM Program based upon MCG Health guidelines and/or nationally recognized, evidence-based clinical guidelines.

Criteria to identify customers who are eligible for the program: Currently WPS Health Plan takes referrals from providers or customers, and uses the following data sources to identify customers for case management:

- **Claims or encounter data:** These reports identify transplant, high-dollar, trauma, emergency room, and chronic illness cases that result in high utilization.
- **Hospital discharge data:** Inpatient prior authorization and concurrent review for all customers allow the opportunity to evaluate the need for coordination of services for customers with complex conditions and help them access needed resources.
- **Discharge planner referrals:** The Nurse Integrated Care Manager and hospital discharge planner evaluate the customer’s discharge needs for continued services and determine if there is a need for case management intervention.
- **Pharmacy data:** Data that identify categories such as high-dollar expenditure, therapeutic drugs, new to therapy, and high pharmacy utilization.
- **Data obtained through utilization management:** The prior authorization process assists nurse care managers to identify customers with complex conditions and to evaluate the need for assistance with coordination of care.
- **Data supplied by purchasers, if applicable**

Services offered to customers

During the CCM process, the Nurse Case Manager:

- Performs a detailed assessment and clinical history of the customer’s health status specific to identified health conditions and likely co-morbidities.
- Reviews available certificate benefits and directs the customer to in-network providers.
- Facilitates referrals to resources, such as community resources, Employee Assistance Programs (EAP), Population Health Management Program, etc., as well as follows up on whether the customer acted on these referrals as needed.
- Interacts with providers including the customer’s PCP, specialist, DME/infusion company, etc., based on the customer’s current needs.
- Develops and communicates a customer self-management plan with the identification of goals and any barriers to meet those goals. The Case Manager creates a communication schedule with the customer during the CCM process.
Defined program goals
The purpose of the WPS Health Plan CCM Program is to assist customers to regain optimum health or improved functional capability in the most appropriate and cost-effective care setting to meet their needs. The following goals will ultimately assist the organization to reduce costs and add value to customers:

- Customers will be able to obtain access to high-quality care and appropriate services through coordination of care of their health care needs.
- Case Managers will provide support and education to the customers to reach their maximum achievable health potential and independence.
- The customer or caregiver will be self-empowered to know what steps to take if the customer’s medical condition changes.

WPS Health Plan has the following goals to measure the success of the CCM Program:

- To achieve customer satisfaction of 80% or greater as reflected in the annual customer satisfaction survey of the CCM Program.
- To identify improvement measures to increase the effectiveness of its CCM Program (if applicable).

Based on the results of these measures, WPS Health Plan implements interventions and re-measurement, if applicable.
Behavioral Health Care Management

The Behavioral Health Care (BH) Management program provides a mechanism to optimize use of the customer’s health care benefits while providing high-quality, integrated health care to customers with mental and/or substance abuse disorders. Services include, but are not limited to:

- Inpatient, residential, and concurrent authorization
- Prior authorization request review (if applicable)
- Post-service review

The BH Management program does not require the prior authorization process or triage prior to a customer contacting or making an appointment with a behavioral health care practitioner. It’s the practitioner’s responsibility to provide a treatment plan to WPS Health Plan for certain services.

The BH Management Program requires a prior authorization determination for all services referred to inpatient and residential facilities. Our HMO plan requires a prior authorization determination for services referred to non-participating providers. We review these services for customer eligibility, medical necessity, and potential redirection to an appropriate participating practitioner, benefit coverage, and/or coordination of services. The prior authorization process for BH matches our medical prior authorization process, including submission, review, determination notification, and concurrent and post-service reviews.
Pharmacy Benefits Management

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

The WPS Health Plan Director of Pharmacy provides the program leadership.

The WPS Health Plan Pharmacy Program is overseen by the Quality Improvement Committee. The Pharmacy Management Program is reviewed at least annually and updated as needed. Changes to the program are communicated to practitioners via direct mail, email, and/or our website. A current version of the Prescription Drug Program Policy can be found on the Pharmacy Information page at wpshealth.com/healthplan. WPS Health Plan contracts with Express Scripts to process pharmacy claims. Express Scripts is also our exclusive provider of home delivery pharmacy services.

Note: Not all customers receive their drug benefits through WPS Health Plan. Please verify drug benefits by checking the customer’s ID card.

Formulary

A formulary is a list of drugs that can be used by practitioners to identify drugs that offer the greatest overall value. It does not guarantee coverage and should only be used as a guide. Different WPS Health Plan products use different formularies. WPS Formularies may be accessed under Pharmacy Information in the Provider Support and Education section of our website.

Tiered Drug Benefits—Customer Responsibility Determination

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

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

Note: Qualified high-deductible health plans have a combined medical and pharmacy benefit that does not typically incorporate a tiered benefit. Also, certain drugs require an approved prior authorization before being eligible for coverage. Please see the Drug Prior Authorization section for more information.

Covered Drugs

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

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

- Any drug for which there is not a valid prescription order
- Drugs which are not medically necessary
- Drugs used for fertility
- Compounded medications that do not contain at least one legend ingredient
- Nonlegend drugs (those available without a prescription)
- Experimental/investigational drugs
- Replacement medications resulting from loss, theft, or damage
- Any drug used for weight control
- Any drug used for cosmetic purposes
- A covered drug related to a noncovered medical encounter
- Anabolic steroids, unless prior authorization is obtained
- Injectable medications, except as determined by WPS Health Plan or its designee
- Any drug without the proper prior authorization as outlined in the certificate

Generic and Biosimilar Drugs

When an FDA-approved generic version of a brand-name drug is available, WPS Health Plan may limit coverage to the generic form of a drug. The active ingredient(s) in a generic drug is chemically identical to its brand-name counterpart. Pharmacists will dispense the generic medication in this situation. If the prescriber or customer requests the brand, the customer will be responsible for the appropriate copay/coinsurance plus the difference in cost between the brand and the generic. The difference in cost between the brand and generic medication does not apply to the customer’s deductible or maximum out-of-pocket costs.

Biosimilars are not chemically equivalent to brand name drugs, so they can not be classified as generics. However, the FDA considers the differences to be clinically insignificant. FDA-approved biosimilars have undergone clinical studies to ensure they produce the same outcomes as the original brand drug. In appropriate circumstances, WPS Health Plan requires the use of biosimilars in place of the original brand drug.

Drug Therapy—Site of Care Program

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

Drug Prior Authorization

The Drug Prior Authorization List is available online. The list outlines whether Diplomat, Express Scripts, or WPS Health Plan performs the review for the drug in question.

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

- Diplomat (Specialty Drugs) 888-515-1357
- Express Scripts (Traditional Drugs) 800-753-2851
- WPS Health Plan (Other drugs; e.g., hormone-related drugs) 888-711-1444

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

Specialty Drugs

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

Please see our Pharmacy Information page for coverage policies of Specialty Drugs.

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

Nonformulary Exceptions

WPS Health Plan also has a process for the customer’s prescribing physician to request and gain access to nonformulary medications if clinically appropriate drugs are not otherwise covered by the plan. Exceptions can be requested by calling Express Scripts (traditional drugs) at 800-417-8164 or Diplomat (specialty drugs) at 888-515-1357.

Technology and Incentives

Technology Assessment

WPS Health Plan has a policy that establishes procedures for the assessment of new technologies and new applications of existing technologies, including, but not limited to, medical and surgical procedures, pharmaceuticals, and devices. WPS Health Plan has procedures and criteria for the submission and selection of a technology to be considered. The roles of the Medical Policy Committee, Quality Improvement Committee, and Benefits Committee are to determine if the technology will be covered as a WPS Health Plan benefit.

Affirmative Statement on Incentives

Utilization Management decision making at WPS Health Plan is based only on appropriateness of care, service, and existence of coverage. WPS Health Plan does not specifically reward practitioners or other individuals for issuing denials of coverage. No financial incentives are given to encourage decisions that result in underutilization.
Quality Improvement Program

The Quality Improvement (QI) Program is the framework for WPS Health Plan processes and continuous monitoring of our performance according to, or in comparison with, objective, measurable performance standards. The QI Program ensures identification and evaluation of issues that impact our ability to continually enhance our performance and improve the health care and administrative services we provide to our customers.

The scope of the QI Program includes all aspects of services provided by health plan practitioners, providers, and staff. WPS Health Plan arranges for the provision of comprehensive health care delivery through a network of primary care and specialty practitioners, behavioral health practitioners and clinicians, ancillary care providers, hospitals, and other health care facilities. The scope of the QI Program encompasses all care delivered by these practitioners and providers. All WPS Health Plan departments participate in the QI Program. All components of the process are interrelated. The QI Committee directs the review and evaluation of the components, which is initiated at the end of each calendar year.

The scope of the QI Program incorporates components as outlined below. A description of each aspect is found in the Program Components section that follows:

- Regulatory and professional compliance
- Credentialing and re-credentialing
- Population Health Management
- Integrated Care Management
- Behavioral health care
- Care coordination for chronic conditions
- Pharmacy management
- Quality of care and service
- Customer diversity
- Patient safety

WPS Health Plan is dedicated to delivering high-quality services to customers. The following goals are major areas of focus or priority.

The objectives include the major plan-wide initiatives that we will undertake to ensure achievement of each goal. Our guiding principle is to provide services with the following characteristics outlined by the Institute of Medicine:

- Safe
- Timely
- Effective
- Efficient
- Patient/customer-centered
- Equitable

The QI Committee reviews the structure and resources needed to achieve the goals of the QI Program at least annually.
Claim Payment Policies

Electronic Submission Information

WPS Health Plan strongly recommends submitting claims electronically in order to expedite claim processing. This submission format is available for situations in which WPS Health Plan is the primary, as well as the secondary carrier. The WPS Corporate Services—EDI (Electronic Data Interchange) 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.

To begin taking advantage of EDI transactions, you will need to complete our EDI Express Enrollment (E3) process. If you currently send your claims through ClaimsNet clearinghouse, you may continue to do so, and ClaimsNet will forward them to WPS Health Plan.

If you have questions, email edi@wpsic.com or call the EDI Help Desk at 800-782-2680, option 1.

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, which are essential for state, national, and accrediting body reporting, as well as to ensure accurate and timely claim payment:

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

Paper claims submission address:

WPS Health Plan
P.O. Box 21352
Eagan, MN 55121

Timely Filing of Claims

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

The timely filing period for coordination of benefits (COB) claims begins from the date of the primary payer’s explanation of benefits (EOB). WPS Health Plan is not obligated to pay claims received after the timely filing provisions of the WPS Health Plan Provider Agreement or the customer’s benefit plan.
Coding Requirements

- Healthcare Common Procedure Coding System (HCPCS) for Ancillary Services/Procedures
- Code on Dental Procedures and Nomenclature (CDT)
- Current Procedural Terminology (CPT-4) for Physicians Procedures
- International Classification of Diseases, ICD-10
- 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.

Hospital-Acquired Conditions

WPS Health Plan 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.

Reimbursement Policies

When processing claims, we follow industry standards relating to standard billing modifiers and coding similar to those established in UB-04 and CMS’ Medicare Database. To view our reimbursement policies, visit the Provider Resources Support and Education section of our website.

Subrogation

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

Coordination of Benefits (COB)

Coordination of Benefits is administered according to the customer’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 Health Plan 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 customer’s workers’ compensation carrier.

Medical Records and Completion of Care Plans

Providers should allow WPS Health Plan, 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 Participating 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 customer complaints
- Customer grievances/appeals
- Internal and external claim audits
- Pre-existing conditions (grandfathered plans)

**Claim Edit System®**

WPS Health Plan uses Claim Edit System® (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 Health Plan provides an online tool for providers to simulate code combinations for professional services billed on a HCFA 1500 claim form. Providers can enter procedure codes, modifiers, diagnosis codes, date of service, patient gender, date of birth, and place of service parameters to review results specific to the procedure codes being billed. The results and rationale will be displayed and can be downloaded as a PDF. This online tool allows for greater transparency of the code combination edits applied by WPS Health Plan.

The CES application is available to all contracted providers through the Provider Portal. If you do not currently have a provider account, please complete Request for Provider Access on our website.

**Claim Reviews and Claim Audits**

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

**Overpayments**

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

When an overpayment is not received within the time period specified, WPS Health Plan will apply the overpaid amount to any future claims that the provider submits. Please see our Provider Offset tip sheet for details.

**Claim Correction/Resubmission**

On occasion, you may need to correct a claim that has already been processed by WPS Health Plan. Corrected claims are accepted up to 180 days from the original process date listed on your Provider Remittance Advice (PRA).

**Electronic Claim**

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

**Reminders:**

- Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in the CLM*05 03.
- Enter the original claim number in the 2300 loop in the REF*F8*.
Paper Claim
When submitting a corrected claim via paper submission, include the Corrected Claim Form found on the Provider Forms and Documents section of our website. Be sure to use the appropriate bill type for the services being provided in box 4 of the UB form and box 22 of the HCFA form. This will allow us to process your corrected claim in a more timely manner. Paper corrected claims sent without the cover sheet will be returned to you.

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

Claim Reconsideration
If you feel a claim has not been paid correctly, or that services have been inappropriately denied, you or the customer have the right to ask for a review of the claim. Claims eligible for a reconsideration review include issues related to the reimbursement amount, timely filing denials for which you have proof of timely submission, or coordination of benefits (COB) information.

Please send the Claims Reconsideration Request Form, supporting documentation and any correspondence to the address listed on the form.

Provider Appeal Process
A contracted provider may appeal the insurer’s denial with supporting documentation that warrants further review for the following reasons:

• Non-compliance with prior authorization requirements
• Denial of services that are determined to be not medically necessary or experimental, investigational, or unproven

To initiate the provider appeal process, the Provider Appeals Form must be completed in its entirety and submitted to the mailing address listed on the form. Requests that do not meet the appeal criteria listed above, will be returned to the requester.

Our Provider Appeals Committee is composed of representatives from our Claims, Medical Management, Pharmacy, and Compliance Departments. The Committee meets on a monthly basis. The Committee will notify the requester of the review’s results in writing.

Customer Rights And Responsibilities
The Customer Rights and Responsibilities listed below set the framework for cooperation among covered persons, practitioners, and WPS Health Plan.

Rights as a Health Plan Customer

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

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

Customer’s Protected Health Information

WPS Health Plan takes our customers’ privacy seriously and we only use or disclose protected health information in accordance with state and federal law. WPS Health Plan uses and discloses health information about customers for payment and health care operations (including efforts to track Quality Improvement activities), and for their treatment.

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

Customers have the right to look at or receive copies of their health information, with limited exceptions. Please visit wpshealth.com/healthplan for more information.

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

We may disclose summary information about the participants in a particular group plan to the employer. This summary is stripped of any personal information and contains only general statistics about the types and costs of claims. Employers may use this information to obtain premium bids for health insurance coverage.

Your agreement with WPS Health Plan requires you to safeguard all individually identifiable health information, to protect the confidentiality and integrity of all health care information exchanged with WPS Health Plan. You must comply with all applicable laws regarding health information, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent amendments concerning privacy, security, and electronic transactions.

If you want more information about our privacy practices, or have questions or concerns, visit our website at wpshealth.com/healthplan or contact our Privacy Officer at:

Email: WPSprivacyofficer@wpsic.com
Phone: 608-977-7500

WPS Health Plan
Privacy Office
1717 W. Broadway • P.O. Box 8190
Madison, WI 53708-8190
Customer Grievance Procedures

This section includes the appeal rights and grievance procedure for covered persons of plans that are governed by the Employee Retirement Income Security Act of 1974 (ERISA). Customers 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.

Many grievances are based on adverse benefit determinations which deal with a denial, reduction, or termination of a benefit, or a failure to make payment for a benefit. For fully insured plans, a grievance can also be based on any dissatisfaction with the administration, claims practices, or provision of services by WPS Health Plan that is expressed in writing to the WPS Health Plan Grievance department, by, or on behalf of, a covered person. A Grievance Committee is convened every other Tuesday to review all grievances. The Grievance Committee is comprised of WPS Health Plan representatives, including a clinical representative, and an enrollee.

Any covered person who files a grievance will be notified of his/her right to appear in person before the Grievance Committee. The covered person, or an authorized representative, may present written or oral information and ask any questions relating to the grievance. WPS Health Plan will send the covered person written notice of the time and place the covered person may appear before the Grievance Committee at least seven calendar days prior to the Grievance Committee meeting date. Following a thorough review of the case, the Grievance Committee votes on the resolution. A resolution letter is sent within 10 calendar days.

Grievances are generally resolved within 30 calendar days. However, if the Grievance Committee needs additional information to make their determination, an extension may be requested. If the person’s medical condition warrants, the grievance may be expedited and resolved within 72 hours.

Independent Review

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

- Cosmetic
- Not medically necessary
- Experimental, investigative, or unproven

This includes the denial of a referral request if the customer has a referral requirement in their HMO or POS plan and the customer believes that the clinical expertise of the out-of-network provider is medically necessary.

Benefits specifically excluded from the customer’s benefit plan are not eligible for independent review. Customers may request an independent review if their policy is rescinded.

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

  WPS Health Plan
  Attn: Grievance Coordinator
  P.O. Box 11625  |  Green Bay, WI 54307-1625
  Fax: 608-327-6320
  Urgent Fax: 608-327-6322

Contact Information

For additional information on grievance, appeals, and independent review, please see our website at wpshealth.com/healthplan.
Office of the Commissioner of Insurance (OCI)
In addition to a WPS Health Plan grievance/appeal, customers 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
P.O. Box 7873
Madison, WI 53707-7873
Phone: 608-266-0103
Toll-Free: 800-236-8517
Email: ocicomplaints@wisconsin.gov
Website: oci.wi.gov

Continuity Of Care
Under certain circumstances, if a covered person’s PCP or specialist leaves our network, the covered person may continue to receive care from that practitioner.

We will continue to provide coverage for services from a practitioner who terminates from WPS Health Plan under the following circumstances:

- The practitioner continues to practice within the geographical service area.
- The practitioner did not terminate with the health plan due to misconduct.
- We represented that the practitioner was, or would be, participating in WPS Health Plan marketing materials available to the covered person at the time of their initial enrollment, most recent coverage renewal, or most recent open enrollment period, whichever is later.
- If the practitioner is the covered person’s PCP at the time of termination, we will continue to cover services provided by that practitioner until the end of the plan year.
- If the covered person is undergoing a course of treatment with a specialist who terminates, we will continue to cover non-maternity services from that specialist for the following period of time:
  - For the remainder of the course of treatment or for 90 calendar days after the specialist’s participation terminates, whichever is shorter.
  - Certain groups cover specialty services until the end of the current plan year for which it was represented that the specialist was, or would be, participating.
- If the covered person is receiving maternity care from a practitioner other than the covered person’s PCP, and the covered person is in the second or third trimester of pregnancy when the practitioner’s participation terminates, we will continue to cover practitioner’s services from that provider until the completion of postpartum care for the mother and infant.

Notification to Customers Affected by the Termination of a Specialist or PCP
WPS Health Plan takes responsibility for notifying affected customers of specialist or PCP terminations from the network and options for receiving continued care. Notification is not done if the specialist or PCP moves outside the service area, is terminated for cause, retires, or is no longer caring for patients in the same manner as their prior practice.
Definitions

Integrated Care Management Definitions

Many of the definitions below are derived from WPS Health Plan customer certificates, which may vary depending on the type of plan the customer purchased.

Concurrent Care Decision: A decision by us to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by us or a decision with respect to a request by you to extend a course of treatment beyond the period of time or number of treatments that has been approved by us.

Cosmetic Treatment: Any health care service: (1) used solely to improve the patient’s physical appearance or self-esteem; (2) treatment of a condition that causes no functional impairment or threat to the patient’s health.

Experimental/Investigational/Unproven: Any health care service, treatment, supply, or facility that meets at least one of the following:

- Is not currently recognized as accepted medical practice as determined by our Medical Director.
- Is not recognized as accepted medical practice at the time the charges were incurred, as determined by our Medical Director.
- Has not been approved by the United States Food and Drug Administration upon completion of Phase III clinical investigation.
- Is used in a way that is not approved by the United States Food and Drug Administration (FDA) or listed in the FDA-approved labeling, except for off-label uses that are accepted medical practice.
- Has not successfully completed all phases of clinical trials, unless required by law.
- Is a treatment protocol based upon, or similar to, those used in ongoing clinical trials.
- Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that the treatment is safe and effective for the condition.
- There is not enough scientific evidence to demonstrate or make a convincing argument that (a) it can measure or alter the sought-after changes to the illness or injury or (b) such measurement or alteration will affect the health outcome; or support conclusions concerning the effect of the drug, device, procedure, service, or treatment on health outcomes.
- Is associated with Category III CPT code developed by the American Medical Association.

Note: The above list is not all-inclusive.

A service, supply, treatment, or facility may be considered experimental, investigational, unproven, and not medically necessary even if the provider/practitioner performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

We have full discretionary authority to determine whether a health care service is experimental/investigational/unproven. In any dispute arising because of our determination, such determination will be upheld if the decision is based on any credible evidence. If our decision is reversed, the only remedy will be our provision of benefits in accordance with the customer’s policy. The customer will not be entitled to receive any compensatory, punitive damages, attorney’s fees, or any other costs in connection therewith or as a consequence thereof.

References used in the evaluation include, but are not limited to, Medical Management Medical Policy, MCG Health, Hayes, The American Cancer Society, The American Medical Association, FDA, U.S. Department of Health & Human Services (i.e., CMS), National Library of Medicine Search, National Institutes of Health, PubMed (Medicine), Cochrane Library, National Comprehensive Cancer Network (NCCN), National Guidelines Clearinghouse, National Cancer Network, Recommendations of the U.S. Preventive Services Task Force (USPSTF), and/or Specialty Society guidelines and standards (e.g., The American Academy of Pediatrics, American Colleges Physicians), and review of information from appropriate government regulatory bodies.
**Medically Necessary:** A health care service, treatment, supply, or facility that WPS Health Plan determines to be:

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

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

As defined by NCQA, Integrated Care Management uses the following definitions to assist in making authorization decisions.

**Non-Urgent Request:** A request for medical care or services for which application of the time period for making a decision does not jeopardize the life or health of the customer or the customer’s ability to regain maximum function and would not subject the customer to severe pain.

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

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

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

Emergency Medical Care

Emergency Medical Care is defined as health care services to treat a medical emergency.

A medical emergency is a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would 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.

Examples of emergency conditions include, but are not limited to:

- Loss of consciousness
- Severe burns
- Heavy bleeding
- Possible heart attack

For emergency conditions in our service area, the customer should access the closest in-network hospital emergency facility. When out of our service area, the customer should access the closest hospital emergency facility. Follow-up care should be arranged through the PCP.

Urgent Care

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

Examples of urgent care situations include, but are not limited to: sprained ankle, minor cut, minor burn, and children with fever. In these situations, the customer should contact their PCP. During business hours, services for urgent situations should be received in the PCP office whenever possible. For after-hours services, the PCP office should be contacted for assistance.

Emergency Room and Urgent Care Coverage

In the event of a medical emergency, hospital care is covered wherever it is received. However, if a customer is admitted, a participating PCP must be notified within 48 hours of being medically able. The servicing facility must notify WPS Health Plan within two days of an acute (direct or emergency) admission.

When urgent care is needed for a non-life-threatening illness or injury, customers should contact their PCP prior to seeking care for direction to the appropriate medical facility.

WPS Health Plan provides, arranges for, or otherwise facilitates needed emergency services or instructs customers to call 911. WPS Health Plan will not deny coverage for emergency services for a customer without prior authorization when:

- Such care is received to screen and stabilize the customer where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
- WPS Health Plan will provide coverage for emergency services rendered during the treatment of an emergency medical condition by a non-participating provider as though the services were provided by a participating provider.
- WPS Health Plan will also provide coverage if the enrollee cannot reasonably reach a participating provider, or as a result of the emergency, is admitted for inpatient care subject to any restriction which may govern payment to a participating provider for emergency services.
Emergency Room and Urgent Care Coverage—College Students

- In the event of a medical emergency, the customer is covered regardless of where medical care is received.
- After receiving emergency care, the customer must call his/her PCP or WPS Health Plan Customer Service at 888-711-1444 on the following business day or when able.
- If the customer is admitted to the hospital, the customer must call Customer Service the next business day.
- If the customer is away at college and an acute medical problem develops, the customer should call his/her PCP first. If the PCP cannot handle the customer’s problem, the PCP will refer the customer to the college’s health center, a local physician’s office, or an urgent care center.
- If the customer receives care from a non-participating provider and additional services are needed, the customer will need a prior authorization from his/her PCP and approval from the WPS Health Plan Medical Director. The customer may need to return home to receive treatment from a participating provider. If the customer requires ongoing medical care, the customer will need a prior authorization from his/her PCP and approval from the WPS Health Plan Medical Director.
- Some out-of-area medical facilities not in the WPS Health Plan participating provider network may require the customer to pay for care at the time it is provided. To arrange for reimbursement, the customer should send itemized bills and proof of payment within 90 days to:
  
  WPS Health Plan
  P.O. Box 21352
  Eagan, MN 55121

  - The customer will be responsible for out-of-area charges that exceed the maximum out-of-network allowable fee. Routine care should be received from a participating PCP when the customer is in the WPS Health Plan service area.
  - If the customer has additional questions, contact Customer Service at 888-711-1444.
**Telemedicine**

*Telemedicine* is defined as the delivery of clinical health care services via telecommunications technologies, including, but not limited to, telephone and interactive audio and video conferencing.

Covered telemedicine services include:

- Telemedicine services provided by a health care practitioner to a covered person via telephone or interactive audio-visual telecommunication to treat a covered illness or injury
- Telemedicine services provided by our designated telehealth service provider

Visit our [Telehealth page](#) or call the telephone number shown on your identification card for additional information about this benefit.

The following services are not considered telehealth:

- Transmission fees
- Website charges for online patient education material
- Telecommunications, including, but not limited to, instant messaging, text messaging, email communication or facsimile communication.

**Convenient Care Clinic**

A *Convenient Care Clinic* is defined as a medical clinic located within a retail store, supermarket, or pharmacy. The clinic must provide covered health care services by a health care practitioner. The covered health care services must be provided within the scope of the health care practitioner’s respective license.

Under our customer’s health care plans a health care practitioner is generally defined as one of the following licensed practitioners who perform services payable under the customer’s plan: a Doctor of Medicine (MD); a Doctor of Osteopathy (DO); a Doctor of Podiatric Medicine (DPM); a Doctor of Dental Surgery (DDS); a Doctor of Dental Medicine (DMD); a Doctor of Chiropractic (DC); a Doctor of Optometry (OD); a physician assistant (PA); a nurse practitioner (NP); a certified nurse midwife (CNM); a psychologist (PhD, PsyD); a licensed mental health professional, including but not limited to, a clinical social worker, marriage and family therapist, or professional counselor; a physical therapist; an occupational therapist; a speech-language pathologist; an audiologist; or any other licensed practitioner that is acting within the scope of their license and performing a service that would be payable under the customer’s health care plan.

**Revisions**

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