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

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

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

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

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

Insuring Wisconsin’s Health Since 1946
WPS Health Insurance has deep Wisconsin roots grounded in events that transformed health care practices in the United States. The Great Depression exposed the financial vulnerability of health care providers throughout the United States, encouraging them to turn to health insurance as a solution. Responding to concerns, legislators authorized the State Medical Society to establish not-for-profit health insurance plans.

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

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

Statewide Provider Network
The WPS Statewide Network is a broad network ideal for groups with employees throughout the state. Employees enjoy convenient access to a wide range of providers across Wisconsin. Anyone covered under the WPS Statewide Network can enjoy in-network benefits when they visit preferred out-of-state providers through our National Network Wrap. The WPS Statewide Network is also available to individual health plan customers.

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

### Provider Services: Provider-dedicated customer service line

<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-765-4977</td>
<td>608-223-3626</td>
<td>To send a secure message to Customer Service, log in to your provider account: wpshealth.com/providers/index.shtml</td>
</tr>
</tbody>
</table>

Hours: Monday through Friday, 7:30 a.m. to 5 p.m. CT

### Contact Provider Services for:

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

### Claims Filing Address

<table>
<thead>
<tr>
<th>Claims Filing Address</th>
<th>Claim Correspondence Address (Questions on claim processing or payment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WPS Health Insurance</td>
<td>WPS Health Insurance</td>
</tr>
<tr>
<td>P.O. Box 21341, Eagan, MN 55121</td>
<td>P.O. Box 8190, Madison, WI 53708</td>
</tr>
</tbody>
</table>

### Electronic Data Interchange (EDI) Help Desk

<table>
<thead>
<tr>
<th>Toll-Free</th>
<th>Email</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-782-2680, Option 1</td>
<td><a href="mailto:edi@wpsic.com">edi@wpsic.com</a></td>
<td>wpshealth.com/resources/provider-resources/edi</td>
</tr>
</tbody>
</table>

Hours: Monday through Friday, 7:55 a.m. to 4:30 p.m. CT

### Contact the EDI Help Desk for:

- Questions about online registration
- How to log in
- Missing files
- Other technical concerns

### Corporate (Do not use for claims submission; see Claims Filing Address above)

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Office Address</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 8190</td>
<td>1717 W. Broadway</td>
<td>wpshealth.com</td>
</tr>
<tr>
<td>Madison, WI 53708</td>
<td>Madison, WI 53713</td>
<td></td>
</tr>
</tbody>
</table>
### Provider Relations

<table>
<thead>
<tr>
<th>Phone: 920-490-6903</th>
<th>Fax: 608-977-9939</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact the Provider Relations team for:</strong></td>
<td><strong>Contact the Provider Relations team for:</strong></td>
</tr>
<tr>
<td>• Fee schedule inquiries</td>
<td>• Provider directory/website listings</td>
</tr>
<tr>
<td>• Provider contracts</td>
<td>• Reimbursement policies</td>
</tr>
</tbody>
</table>

#### 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

#### 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

#### 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

#### Southeastern Wisconsin

Jessie Evans, Provider Network Coordinator  
920-977-6582  
Jessie.Evans@wpsic.com

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

### Provider Credentialing

<table>
<thead>
<tr>
<th>Credentialing Manager</th>
<th>Senior Credentialing Specialist</th>
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<tbody>
<tr>
<td>920-490-6952 (Direct)</td>
<td>920-977-6613 (Direct) or 608-221-5479 (Fax) <a href="mailto:ProviderCredentialing@wpsic.com">ProviderCredentialing@wpsic.com</a></td>
</tr>
</tbody>
</table>

**Contact Provider Credentialing with questions concerning:**

- Initial credentialing
- Re-credentialing

### Independent Chiropractors

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

<table>
<thead>
<tr>
<th>Magellan Healthcare</th>
<th>Main Phone</th>
<th>Toll-Free</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>7805 Hudson Road, Suite 190 St. Paul, MN 55125</td>
<td>952-225-5732</td>
<td>800-432-3640</td>
<td>888-656-1913</td>
</tr>
</tbody>
</table>

### Integrated Care Management

<table>
<thead>
<tr>
<th>Toll-Free</th>
<th>Prior Authorization Fax</th>
<th>WPS Employee Group Customer Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-333-5003</td>
<td>608-226-4777</td>
<td>608-226-8016</td>
</tr>
<tr>
<td>608-226-4711</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contact Integrated Care Management for:**

- Pharmacy management
- Medical policies
- iExchange electronic prior authorization request
- Outpatient and elective inpatient prior authorization guidelines (inpatient hospital, residential behavioral health, or skilled nursing facility)
- Inpatient urgent admissions
PRODUCT AND BENEFIT PLANS

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

Preferred Provider Organization (PPO)

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

Copay Plans

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

High-Deductible Health Plans (HDHP)

These plans qualify for use with a Health Savings Account (HSA) that lets customers budget and pay for qualified medical expenses using tax-free dollars.

Network Options

WPS’ provider networks offer convenient access to the physicians and health care facilities Wisconsin residents know and trust. Networks offered vary by product, so please verify provider network(s) shown on the customer’s ID card.

WPS Statewide Network

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

Southern Network

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

HealthyU Network

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

National Network Offerings

Networks offered outside of Wisconsin may vary. If a customer has a national network, the network’s logo will be printed on the customer’s ID card.

Wisconsin Medicare Supplement (Medigap) Health Insurance Plans

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

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

Provider Directory and Demographic Updates
To notify us of roster and location additions, deletions, or changes, complete the Practitioner Data Sheet or Facility Data Sheet found under the Provider Directory & Demographic Updates section of our Forms and Documents page at wpshealth.com. Or you may contact us by phone at 920-617-6325 to request the most current copy of the form.

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

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

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

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

Subcontracts for Covered Services
Each subcontract with licensed persons or entities for the provision of covered services under a PPO Agreement to customers will:
1. Require subcontractors to conform to all terms of the PPO Agreement applicable to the provider.
2. Allow WPS the right to pre-approve or disapprove the right of each individual licensed person or entity to provide covered services to customers.

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

Noncontracted Providers
If interested in participating in the WPS provider network, please visit the How to Become a WPS Health Insurance Provider section of our website.

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

WPS will credential practitioners who have an independent relationship with WPS. An independent relationship exists when WPS contracts with a provider. Once approved, an ongoing assessment (re-credentialing) is conducted at least every three (3) years.

WPS uses a Credentials Verification Organization (CVO) called Eddy. CVO personnel may contact you for information regarding your initial credentialing or recredentialing. Please forward any requested information directly to Eddy by responding to its email, CVO@EddyNow.com. Only information requested by Eddy should be sent to Eddy. All other communications should follow the communication routes previously defined in this document.

Practitioner Credentialing

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

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

**Behavioral Health Care Practitioners**
- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or Master’s level Clinical Psychologists (Ph.D. or Psy.D.)
- Master’s level clinical nurse specialists or psychiatric nurse practitioners (NP, APNP)
- 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 (M.A., M.S., M.S.E., M.S.W.)
- Licensed Behavior Analysts (LBA)

**Allied Health Professionals**

Allied Health Professionals who are not facility-based providers, including, but not limited to:
- Advanced Practice Nurse Prescribers (APNP)
- Master’s Level Nurse Practitioners (NP, FNP, WHNP, etc.)
- Certified Nurse Midwives (CNM)
- Physician Assistants (PA or PAC)
- Audiologists (AuD)
- Registered Dietitians (RD)
- Physical Therapists (PT)
- Speech and Language Pathologists (SLP)
- Occupational Therapists (OT)
- Other Professionals
- Allied health professionals who have an independent relationship with WPS and are not part of an organization or group of practitioners.
- Covering practitioners (*locum tenens*) providing services for a period longer than six (6) months.
- Practitioners who are hospital-based but who see customers outside of the inpatient hospital setting, or free-standing, ambulatory facilities as a result of their independent relationship with WPS (e.g., pain medicine, radiation oncology).
- Rental networks that are part of the WPS network and have 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 medical benefits.
Organizational Provider Credentialing

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

Organizational providers include:

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

WPS will confirm that the organizational provider:

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

Provider Credentialing Rights

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

During the credentialing process:

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

Note: Approval of your credentialing application is not indicative of contract effective date. Contact the Network Development Department at 888-711-1444 or email GBNetworkDevelopmentDept@wpsic.com for your official effective date.
INTEGRATED CARE MANAGEMENT (ICM)

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

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

The program is designed to make utilization decisions affecting the health care of customers in a fair, impartial, and consistent manner. The WPS ICM Program provides a systematic method to manage customer utilization of services. 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
The main goal of the Integrated Care Management (ICM) Program is to oversee the quality of relevant care while promoting appropriate utilization of medical services and plan resources.

The objectives of the ICM Program are to:

Provide a structured process to continually monitor and evaluate the delivery of health care 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 and the ICM program.
- Monitoring indicators to detect possible under- and over-utilization of services.
- Auditing of denial decision timeliness and consistency.
- Conducting inter-rater reliability audits of all licensed Integrated Care Managers and the Medical Directors.

The following resources/tools support the ICM Program:

- Clinical experts
- Clinical practice guidelines
- Conferences/seminars
- Definitions from the Certificate of Coverage
- External review
- Literature
- Nationally published and locally developed Utilization Management criteria
- Policies and procedures

The ICM team collects data on practitioner satisfaction with the Utilization Management process and reports this information to the Quality Improvement (QI) committee for review and action, as it deems necessary.
Improve clinical outcomes through:

- System-wide collaboration to identify, develop, and implement clinical practice guidelines and programs that address key health care needs of the customers.
- Implementation of clear, consistent ICM requirements and key success indicators.
- 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 among the QI team, Medical Director, the 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 resources through efficiency of service.

Meet or exceed established quality standards by:

- Meeting all appropriate regulatory requirements.
- Ensuring consistency in ICM decision-making.
- Rendering timely ICM determinations and issuing timely notifications of decisions.

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

- The ICM team collects data on practitioner satisfaction with the Utilization Management process and reports this information to the QI committee for review and action, as it deems necessary
- Affirmative statement on incentives
- Behavioral health care management program
- Care coordination program
- Complex case management program
- Concurrent review decisions
- Emergency services
- Health care informatics
- Pharmacy and specialty drug management program
- Physical medicine program, which includes therapy management and chiropractic care management
- Post-service review decisions
- Prior authorization (PA) determination for medical services
- Radiation benefit management program
- Reporting
- Satisfaction with the Utilization Management process
- Technology assessment
- Therapy management program
Tools and Resources

Utilization Review Criteria

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

WPS applies 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 evaluates the consistency with which Integrated Care Managers and the Medical Director apply the criteria when making decisions. WPS will develop a corrective action plan if significant variation is found.

WPS 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 practitioners/providers may review the Integrated Care Management criteria. We provide a copy of specific criteria used for decision-making to any WPS practitioner upon request. This copy is for the practitioner’s own use and may not be released to others without permission from WPS. Practitioners are informed how to request criteria when the determination is made 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 intends to administer its Integrated Care Management (ICM) program. The Quality Improvement 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’ practitioner panel, many of whom are board-certified and participate on various committees at WPS. WPS also purchases a variety of expert services through external vendors. Examples of expert vendors used are:

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

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. For a complete list, see the Medical Policies section of our website.

Practice guidelines are not intended to determine plan benefits and do not reflect coverage. Benefit coverage varies by group and should be verified prior to services being rendered.
MEDICAL POLICIES 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/investigational determinations. The WPS Medical Policy Committee is responsible for the development of internal medical policies.

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

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

WPS Health Insurance
Attn: Medical Management Department
P.O. Box 8190
Madison, WI 53708-8190
Phone: 800-333-5003
Fax: 608-226-4777

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

Prior Authorization Definition
Prior authorization is the process of receiving written approval from WPS 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 select services. Please refer to wpshealth.com for the Prior Authorization List to verify prior authorization requirements.

A prior authorization is not required for:
- Services performed by a preferred provider, including a preferred provider who specializes in obstetrics or gynecology, except for those services listed on the prior authorization list located on wpshealth.com
- Emergency care or urgent care at an emergency or urgent care facility
- Covered radiologist, pathologist, and anesthesiologist services at a participating facility

Prior Authorization Process
Based on the medical complexity of services, we expect preferred 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 customer for services that have been denied by WPS, and thereby rendered non-covered services, because of (a) the provider’s failure to follow the Program, or (b) WPS’ determination that such services are not medically necessary pursuant to the WPS customer’s health benefit plan; or (c) WPS’ determination that such services are experimental/investigational/unproven pursuant to the WPS customer’s health benefit plan. The provider may collect fees for services that are not covered services when the provider delivers such services on a “fee for service” basis with the WPS customer’s prior, written acknowledgement and consent.

We encourage customers to verify prior authorization is requested by their provider and approved by WPS.
- Provider should verify customer eligibility and benefits through the Provider Portal or by calling Customer Service at 800-765-4977.

Services that are exclusions of the customer’s health plan or listed on the Noncovered 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: Facility must notify WPS 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
iExchange® Web Portal

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

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

Benefits of iExchange

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

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

Enroll in iExchange

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

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

To learn more about iExchange and request passwords or training, visit the WPS iExchange Web Portal.

Magellan Healthcare Web Portal for Rehabilitative Therapy Authorizations

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

Benefits of Magellan Healthcare Portal

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

Using the Magellan Healthcare Portal

If you already have an account with Magellan Healthcare, you can use the same account to request services for WPS 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

The pediatric vision care benefit is offered on limited plans (individual and small group plans that comply with the Affordable Care Act only) to customers who are under age 19. Please contact Customer Service for specific coverage information and prior authorization guidelines.

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

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

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

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

Eyeglasses and eyeglass component parts not provided by the WPS contracted vendor will not be reimbursed by WPS without prior authorization. Providers cannot bill the customer without prior written acknowledgment and consent of the customer.
Radiology Benefit Management

WPS 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.

Medical Prior Authorization (PA) Determination

Our Integrated Care Management (ICM) team reviews prior authorization requests for benefit coverage, medical necessity, and potential recommendation to redirect to an appropriate preferred practitioner/provider, and/or coordination of care/services. When requests come in, they go through the following process:

- The ICM team obtains all data and relevant information, including, but not limited to, medical records and communications with practitioners or other consultants.
- UM criteria are used to review relevant information as described in the resources/tools section.
- We review inpatient facility care, such as acute, rehabilitation, and/or skilled nursing care, prior to or within 24 business hours of admission, then concurrently according to accepted criteria and guidelines.
- The Medical Director reviews and renders a determination for all potential medical necessity denials.
- The ICM team attempts to contact the attending practitioner prior to making an acute inpatient medical necessity denial.
- Nonurgent PA approval and denial determinations are provided to practitioners and customers via verbal, written, or electronic notification. We provide nonurgent PA denial determinations within 15 calendar days of the request via written or electronic notification.
- Urgent PA approval and denial determinations are provided to practitioners and customers via verbal, written, or electronic notification within 72 hours of the request.
- We send 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.

Written denial determination notifications include:
- The specific reason for the denial.
- A reference to benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.
- An 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.
- A description of appeal/grievance rights, including the right to submit written comments, documentation, or other information relevant to the appeal/grievance.
- An explanation of the appeal/grievance process, including the right to customer representation, and time frames for deciding appeals/grievances.
- For urgent prior or urgent concurrent denial, a description of the expedited appeal/grievance.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care and ongoing treatment.
- Notice of the External Review Process, if applicable.
- Contact information for language assistance.
How will claims be paid if authorized care is received from a nonpreferred provider?

Maximum Allowable Fee levels will apply to nonpreferred providers and services rendered. This means that the customer is responsible for any charge that exceeds the Maximum Allowable Fee level for authorized services received from nonpreferred providers.

Concurrent Review

Concurrent review decisions are reviews for the extension of previously approved ongoing care. This includes the review of inpatient care as it is occurring or ongoing ambulatory care. 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.
- ICM team obtains all data and relevant information, including, but not limited to, medical records and communications with practitioners or other consultants. Information requested for concurrent review should be sent within 24 hours of our request.
- We use Utilization Management criteria to review relevant information as described in the resources/tools 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 Process

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

- Post-service decisions are determinations of medical necessity and/or appropriate level of care when the customer 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 resources/tools section of this manual.
- The Medical Director reviews and renders a determination for all potential medical necessity or inappropriate level of care denials.

PEER-TO-PEER REVIEW

Prior to services being rendered, we offer a peer-to-peer discussion for the ordering provider regarding a prior authorization denial of services that are determined not to be medically necessary or experimental or investigational. It is another opportunity to provide additional information relevant to the denial decision.

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

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

If the decision for denial of services is upheld, the customer has the option to file a grievance/appeal according to directions provided in the denial letter.
COMPLEX CASE MANAGEMENT (CCM) PROGRAM

Complex Case Management 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, and need assistance in navigating the system to receive the appropriate delivery of care and services.

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

Criteria to identify customers who are eligible for the program: Customers can self-refer, providers can refer, and WPS uses the following data sources to identify customers for case management:

- **Claims or encounter data:** These reports identify transplant, high-dollar, trauma, and chronic illness cases that result in high utilization.
- **Hospital discharge data:** 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 helps 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:** This data identifies categories such as high-dollar expenditure, therapeutic drugs, new to therapy, and high pharmacy utilization.
- **Data obtained through utilization management:** The prior authorization process assists nurse Integrated Care Managers in identifying customers with complex conditions and in evaluating the need for assistance with coordination of care.
- **Data supplied by purchasers**, if applicable.

Services Offered to Customers

During the CCM process, the 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 if applicable.
- Facilitates referrals to resources, such as community resources, Employee Assistance Programs (EAP), Health Management, etc., and follows up on whether the customer acted on these referrals as needed.
- Interacts with providers to include 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 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 to meet their health care needs.
- Case Managers will provide support and education to customers in order to reach their maximum achievable health potential and independence.
- The customer or caregiver will be self-empowered to know what steps to take if a medical condition changes.
BEHAVIORAL HEALTH CARE

Benefits

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

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

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

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

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

- Neuropsychological Testing Request Form
- Outpatient Behavioral Health Treatment Request Form

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

- Professional Staff Update Notification
- Autism Spectrum Progress Report Form
**PHARMACY BENEFITS MANAGEMENT**

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

The WPS Director of Pharmacy provides the program leadership.

The WPS Pharmacy Program is overseen by the Quality Improvement team.

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. WPS 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. 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 products use different formularies. They can be accessed online at wpshealth.com under **Pharmacy Information**.

**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.

1. Generic drugs on the formulary carry the lowest responsibility (first tier)
2. Brand-name drugs on the formulary are the middle responsibility (second tier)
3. Brand-name drugs *not* on the formulary carry the highest responsibility (third tier)
4. 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 typically does not 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 requires they must be medically necessary and a prescription must be written.
Commonly Excluded Drugs

- Drugs used for fertility or whose primary use is fertility
- Compounded medications that do not contain at least one legend ingredient
- Nonlegend drugs (those available without a prescription)
- Experimental, investigational, or unproven drugs
- Replacement medications resulting from loss, theft, or damage
- Any drug used for weight control
- Any drug used for cosmetic purposes or whose use is not medically necessary
- A covered drug related to a noncovered medical encounter
- Anabolic steroids, unless prior authorization is obtained
- Injectable medications, except as determined by WPS 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 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/deductible/coinsurance plus the difference in cost between the brand and the generic.

Biosimilars are not chemically equivalent to brand-name drugs, so they cannot 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 requires the use of biosimilars in place of the original brand drug.

Drug Therapy—Site of Care Program

Most WPS 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 of this include having a patient self-administer a drug instead of receiving it in the provider’s office. It could also mean using home care services in place of an infusion center or outpatient hospital setting.
DRUG PRIOR AUTHORIZATION AND NONFORMULARY EXCEPTIONS

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

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

- Diplomat (specialty drugs) 888-515-1357
- Express Scripts (traditional drugs) 800-753-2851
- WPS (other drugs; e.g., hormone-related drugs) 800-333-5003

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

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

See our website, wpshealth.com, for coverage policies for specialty drugs.

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

Nonformulary Exceptions
WPS 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.
QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program is the framework for WPS Health Insurance processes and continuous monitoring of our performance according to, or in comparison with, objective, measurable performance standards. The Quality Improvement 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 Quality Improvement Program includes all aspects of services provided by health plan practitioners, providers, and staff. WPS 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 Quality Improvement Program encompasses all care delivered by these practitioners and providers. All WPS departments participate in the Quality Improvement Program. All components of the process are interrelated. The Quality Improvement Committee directs the review and evaluation of the components, which is initiated at the end of each calendar year.

The scope of the Quality Improvement Program incorporates components as outlined below.

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

WPS 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

Structure

The Quality Improvement Committee reviews the structure and resources needed to achieve the goals of the Quality Improvement (QI) Program at least annually.
CLAIMS PROCEDURES

Electronic Claim Submissions

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

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

To enroll for electronic transactions, please visit the EDI Express Enrollment (E3) section of our website and follow the prompts.

If you have questions, you can email us at 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 requirements, as well as to ensure accurate and timely claim payment:

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

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

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

Timely Filing of Claims

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

The timely filing period for coordination of benefits (COB) claims begins from the date of the primary payer’s EOB. WPS is not obligated to pay claims received after the timely filing provisions of the WPS 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 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 related to standard billing modifiers and coding. Our Reimbursement Policies can be found on our website under Support and Education.

Subrogation

To the extent permitted under applicable state and federal law, and the affected customer’s benefit plan, WPS 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 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
Provider should allow WPS, or any state or federal regulatory agency as required by law, to have reasonable access to provider administrative records as they relate to services provided under an applicable PPO Agreement, including, but not limited to, access to documentation pursuant to applicable Wisconsin Administrative Code.

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

- Utilization or care management reviews
- Quality improvement programs
- Provider or customer complaints
- Customer grievances/appeals
- Internal and external claim audits
- Pre-existing conditions (grandfathered or short-term health plans)

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

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

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 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. 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.

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

Examples of fraud or abuse include:

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

Overpayments
If you identify a claim for which an overpayment has occurred, 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 thirty (30) calendar days or by the time limit specified in your WPS Provider Agreement.

When an overpayment is not received within the time period specified, WPS will apply the overpaid amount to any future claims the provider submits. Please see our Provider Offsets tip sheet for details.
Claim Correction/Resubmission
On occasion, you may need to correct a claim that has already been processed by WPS. 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 a 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*.

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

Paper Claim
When submitting a corrected claim via paper submission, include the Corrected Claim Cover Sheet found on the 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 refile the claim using the WPS original claim identification number referenced on your 835 remit.

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

Please send supporting documentation and any correspondence to our Customer Service Department at:

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

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

1. Noncompliance with prior authorization requirements.
2. Denial of services that are determined to be not medically necessary or experimental, investigational, or unproven.

To initiate the Provider Appeal Process, the Provider Appeal Form must be completed in its entirety and submitted to Provider Appeals. Requests that do not meet the appeal criteria listed above will be returned to the requester.

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

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

MEMBER RIGHTS

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

MEMBER RESPONSIBILITIES AS A HEALTH PLAN MEMBER

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

CUSTOMERS’ PROTECTED HEALTH INFORMATION

WPS takes our customers’ privacy seriously and we only use or disclose protected health information in accordance with state and federal law. Health care operations include efforts to track our quality improvement activities.

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 member, friend, or other person to the extent necessary to help with the customer’s health care or with payment for 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 refer customers to our website for additional information.

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

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

Your agreement with WPS requires you to safeguard all individually identifiable health information to protect the confidentiality and integrity of all health care information exchanged with WPS. 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, or contact our Privacy Officer at WPS, Privacy Office, 1717 W. Broadway, P.O. Box 8190, Madison, WI 53708-8190; WPSPrivacyOfficer@wpsic.com; or 608-977-7500.
CUSTOMER GRIEVANCE/APPEAL PROCESS

This section includes the grievance and appeal rights and procedures for covered persons of plans that are governed by the Employee Retirement Income Security Act of 1974 (ERISA). 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. Typically, the term grievance is used to refer to requests for review under fully insured plans, while appeal is used to describe requests for claim review under self-funded plans. This section refers to grievances as shorthand for grievances and appeals.

Many grievances are based on adverse benefit determinations which deal with a denial, reduction, or termination of a benefit, or a failure to provide or 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 that is expressed in writing to the WPS Grievance department, by, or on behalf of, a covered person.

The Grievance Committee is composed of at least four voting members from various WPS departments, plus a medical advisor, legal advisor, quality advisor, and a provider relations advisor.

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

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

Grievances are generally resolved within 60 calendar days. If the person’s medical condition warrants, the grievance may be expedited and resolved within 72 hours.
**Independent Review Process**

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 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 primarily for one of the following:

- Cosmetic purposes
- Not medically necessary
- Experimental
- Investigative
- Pre-existing condition

Customers may also request an independent review if they disagree with our determination regarding the diagnosis and level of service for treatment of autism. The treatment must be a covered benefit under the insurance plan; benefits specifically excluded from the customer’s benefit plan are not eligible for independent review.

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

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

**Office of the Commissioner of Insurance (OCI)**

In addition to a WPS grievance/appeal, 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  
Complaints Department  
125 South Webster Street  
P.O. Box 7873  
Madison, WI 53707-7873

Phone: 608-266-3585  
Toll-Free: 800-236-8517  
Email: ocicomplaints@wisconsin.gov  
Website: oci.wi.gov
DEFINITIONS

Service Definitions

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

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

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

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

Emergency medical care does not include nonemergency, routine health care, dental, or maintenance treatment, services and supplies, and/or routine medical exams.

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

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

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

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

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

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.

1. Covered telehealth services:
   - Telemedicine services provided by a health care practitioner to a covered person via interactive audio-visual telecommunication to treat a covered illness or injury.
   - Telephone and interactive audio and video conferencing provided by our approved telehealth service providers. Visit our telemedicine page or call the Customer Service telephone number shown on the customer’s identification card for additional information about this benefit.

2. Telehealth exclusions:
   - Transmission fees.
   - Website charges for online patient education material.

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.
Integrated Care Management Definitions

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

**Concurrent Care Decision:** A decision by us to reduce or terminate benefits otherwise payable for a course of treatment that was approved by us or a decision with respect to a request to extend a course of treatment beyond the period of time or number of treatments that was 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 patient’s health.

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

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

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

The above list is not all-inclusive.

**Integrated Care Management:** A general term encompassing activities such as case management, health management of chronic conditions, utilization management, and the clinical aspects of quality management.
**Medically Necessary:** A health care service directly provided to the customer by a health care provider that is required to identify or treat illness or injury and which is determined by WPS to be:

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

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

**Post-Service Claim:** Any claim for a benefit under the Policy that is not a pre-service claim.

**Prior Authorization:** Written approval that you must receive from us before a covered person visits certain health care providers or receive certain health care services.

**Reconstructive Surgery:** Surgery performed on abnormal structures of the body caused by (1) congenital defects; (2) developmental abnormalities; (3) trauma; (4) infection; (5) tumors; or (6) disease.

**Urgent Claim:** Any pre-service claim for medical care or treatment where application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or in the opinion of a health care practitioner with actual knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
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