



WEA Trust Provider Manual 2020

WEA TRUST PROVIDER MANUAL

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Introduction

This provider manual was designed and produced to provide participating providers and their office staff a source of readily available information regarding the administration of WEA Trust.

Founded by Wisconsin Education Association Council (WEAC) in 1970, the not-for-profit WEA Trust has been serving all Wisconsin public employers, their staffs and families. Well-known for personal customer service, WEA Trust has expanded from our origins of insuring only public school employees. Today, we have a diverse clientele of all Wisconsin public employees—school, municipal, county and state.

An alternative to large national carriers, WEA Trust is an independent, not-for-profit company based in Madison, with a Wisconsin staff proud to serve those who serve Wisconsin. Our high-touch service and medical management strive to make a difference in the lives of our members and customers, focusing on getting members the right care at the right time for the right price.

[A Board of Trustees](#) oversees WEA Trust operations and serves without financial compensation.

WEA Trust Mission, Vision and Values

Mission

- Quality insurance, excellent service

Vision

- The preferred health plan of members and public employers

Core Values

- Integrity
- Commitment
- Respect
- Excellence

At WEA Trust, we believe it is our responsibility to assist physicians and their teams to bring the best safe care to the members that choose us. We want to support healthcare that achieves the following:

- Help keep members as healthy as possible, coordinating their care
- When members need care, the care is appropriate, according to their specialty guidelines
- We achieve best quality with the least invasion possible
- Shared decisions, including advance care planning
- When medications are used to treat, we want to encourage members to be adherent to advice, and to have the care team using as few medications as possible to effectively treat the patient.

The core value that we want for our members is for the careful assessment and treatment decisions, this is where we wish to primarily invest. We value physicians and their teams that make a safe environment with low infection and complication rates, as though we are providing care for one of our family members.

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How to Contact WEA Trust

HOURS: Monday through Friday: 7:30 a.m. to 5:00 p.m.

Telephone: 800.279.4090

Fax: 608.276.9119

Correspondence Mailing Address:

WEA Trust
P.O. Box 21538
Eagan, MN 55121-5038

Physical Address:

WEA Trust
45 Nob Hill Road
Madison, WI 53713
[View map](#)

Claims Mailing Address:

WEA Trust
P.O. Box 211438
Eagan, MN 55121-3038

Chiropractic Claims Address:

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

Visit WEA Trust's website at www.weatrust.com. You'll find useful information, tools, and resources for WEA Trust providers, members, and employers.

Our Provider Directory is available [online](#).

The [WEA Trust Provider Portal](#) is a secure, on-line resource designed to help you with day-to-day interaction with WEA Trust. By registering, you will be allowed to check claim status, verify patient eligibility, view coverage information, submit and check status of preauthorizations, send and receive secure messages, and send claim resubmissions.

Whistleblower Hotline

WEA Trust offers an anonymous whistleblower hotline to report violations, suspected violations of law or any unethical or unlawful business practices. The hotline is available 24 hours a day, 7 days a week.

How to Submit a Report:

Phone: 833.480.0010

Fax: 215.689.3885

Email: reports@lighthouse-services.com

Web: www.lighthouse-services.com/weatrust

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Products and Benefit Plans

WEA Trust offers a wide variety of benefit plans. The following is an overview of the plan types offered by WEA Trust.

Standard Health Plans

Standard Health Plans provide comprehensive health coverage to public school districts in addition to county and municipal employers. Groups have several network options; WEA Trust Preferred Network (a broad-based PPO network) and narrow networks (Mayo Clinic Health System, Chippewa Valley Network, and Trust East). Groups also have a variety of plan design and cost sharing options to choose from.

High Deductible HSA Qualified Plans

High Deductible HSA Qualified Plans are also available to public school districts, county and municipal employers and are designed to meet the federal requirements of a High Deductible Health Plan that can be matched with a Health Savings Account. With these plans, the deductible must first be met before other cost-sharing is applied. Groups can choose from the same networks as the Standard Health Plans. There are fewer plan design options allowed, primarily because the law limits what cost-sharing options are available.

State Health Plan

WEA Trust is one of 18 health plans offered to state and local employers participating in the State Health Plan. Employees choose which plan they want to enroll based on those carriers available in their area. The State's Department of Employee Trust Funds (ETF) defines the benefits available under the state health plan and different options are available. WEA Trust has three narrow network options covering most counties in the State. In the Northwest, employees have to select one of two networks; the West-State Plan Chippewa Valley Network or the West-State Plan Mayo Health System Network. In the East, employees have one network available; the State Plan East Network.

WEA MedPlus

WEA Trust MedPlus is wraparound coverage available to individuals enrolled in Medicare and who were previously employed by a public employer. It's a comprehensive benefit except that prescription drugs are not covered under the plan. Members are not limited to a network, but they will receive the most benefit if they see a provider that accepts Medicare assignment.

NVA

WEA Trust offers a stand-alone vision plan to public school districts and county and municipal employers in partnership with National Vision Administrators (NVA). WEA Trust does the enrollment and billing, while NVA contracts with providers and administers the claims.

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Exclusions and Limitations

[WEA Trust Group Plans General Exclusions](#)

General Exclusions and Limitations: Medical

Testing, Services and Procedures

- Experimental/investigational treatments and services.
- Bariatric surgery, including gastric restrictive, bypass and other similar surgeries, and treatment of any related complications.
 - This exclusion applies regardless of your diagnosis or the reason the surgery was performed.
- Weight loss or weight control programs, services and surgeries for the treatment of obesity, including bariatric surgery.
 - We also exclude coverage for complications that are related to any of these programs, services, treatments or surgeries.
 - This exclusion does not include any weight loss or weight control services that we are required by law to cover.
- Routine Foot Care
 - This exclusion does not apply to Routine Foot Care provided to Members with a confirmed diagnosis of:
 - Diabetes;
 - Peripheral neuropathies (as determined by Us);
 - Arteriosclerosis; or
 - Chronic thrombophlebitis
- Private duty nursing services.
- Services or equipment to prevent Injury or to help or make physical activity or sports possible.
- Services to prevent Illness, except those services expressly listed in this “Specific Benefit Provisions” section of this Certificate, or that we are otherwise required by law to cover.
- Services or items for physical fitness, wellness, health education or personal hygiene.
- Services to educate you or help you adapt to a diagnosis or a chronic physical or mental condition. Examples include:
 - Stress management classes; and
 - Classes, education and awareness training for individuals suffering from chronic pain.
- In the absence of an Illness or Injury, services to help you improve your existing physical or mental health and sense of wellbeing.
- Services to treat impotence and erectile dysfunction.
- Removal and treatment of skin tags.
- Services for the sole purpose of improving appearance. Examples include, but are not limited to:
 - Services to improve skin appearance;
 - Cosmetic Surgery;
 - Services to treat and/or remove keloids;
 - Services to repair scarring or disfigurement caused by body piercing, tattooing, implants or other services or procedures which were:

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- Not Medically Necessary;
- Not Medically Appropriate; or
- Not performed by a licensed medical professional.
- Services for male or female baldness or hair loss regardless of the cause. This includes, but is not limited to:
 - Hair restoration;
 - Hair transplants; and
 - Hair implants.
- Services or supplies intended primarily for convenience or the personal preference of:
 - You;
 - Your Immediate Family;
 - The Health Care Provider; or
 - Any other person.
- Services or interventions that have not been documented as being safe and effective for a specific Illness or Injury.
 - This exclusion applies even if the service or intervention was potentially helpful.
 - Examples include, but are not limited to:
 - Acupuncture;
 - Acupressure;
 - Alternative nutritional therapy;
 - Aromatherapy;
 - Ayurvedic medicine;
 - Bioelectromagnetic therapy;
 - Biofeedback, unless provided by a physical therapist or a certified mental health or substance use professional to treat headaches or spastic torticollis;
 - Energetic therapy;
 - Guided imagery;
 - Herbal medicine;
 - Hypnosis and hypnotherapy;
 - Homeopathy;
 - Iridology;
 - Light box therapy;
 - Macrobiotics;
 - Manual healing;
 - Meditation;
 - Mind/body control therapy;
 - Naturopathy;
 - Reflexology;
 - Relaxation techniques;
 - Rolfing;
 - Services provided by a massage therapist;
 - Traditional and/or ethnomedicine therapy; and
 - Yoga.
- A medical service that has not been proven to be both safe and effective through:
 - Randomized clinical trials; and
 - Recognition by a significant portion of the medical community that specializes in the relevant medical field.

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- Custodial or Long-Term Care.
- Any services you receive after your health condition has stabilized and you have reached your expected level of improvement or resolution.
- Holistic or homeopathic remedies and preparations.
- Any services you receive as a result or complications resulting from leaving a licensed medical facility against the advice of medical professionals.
- Any services you receive as a result of complications of a non-Covered Service.
- Any services which are not documented in the Provider's records.

Prescription Drugs and Other Equipment, Devices or Items

- Prescription drugs and other devices or items for the treatment of obesity.
- Replacement of Prescription Drugs or medications, orthotics, or equipment that are:
 - Lost;
 - Stolen;
 - Damaged;
 - Misplaced;
 - Missing; or
 - Otherwise compromised.
- Augmentative and/or alternative communicative devices and systems.
- Tobacco cessation aids, except for the specific prescription and over-the-counter aids described in the "Tobacco Cessation Benefits" subsection of this Certificate.
- Enuresis alarms.
- Appliances for snoring.
- Continuous passive motion (CPM) machine.
- Equipment or services to prevent Injury or to help or make physical activity or sports possible.
- Any immunizations you get for the sole purpose of traveling outside of the United States.
- Items or services for physical fitness, wellness, health education or personal hygiene.
- Vitamins.
- Nutritional or diet supplements, except for those we are required by law to cover.
- Prescription Drugs, equipment, devices or other items to treat impotence and erectile dysfunction.
- Drugs and injections for male or female baldness or hair loss regardless of the cause. This includes, but is not limited to:
 - Hair restoration;
 - Hair transplants; and
 - Hair implants.
- Holistic or homeopathic remedies and preparations.
- Any supplies or equipment you can purchase over-the-counter without a prescription. This includes, but is not limited to, items such as gauze, bandages and tape.

Therapies

- Vocational rehabilitation, including work-hardening programs.
- Gene therapies, treatments or enhancements.

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- While we never reimburse for gene therapies, treatments or enhancements, we reimburse for the Genetic Testing and/or genetic counseling described in the “Genetic Testing/Counseling” subsection of this Certificate.

General Exclusions and Limitations: Non-Medical

Appointments and Other Types of Visits

- Missed appointments.
- Office Visits, Physician charges, or any other service for or connected to a procedure or service that this Policy does not cover.
 - This exclusion applies even if you were not covered under this Policy when the noncovered procedure or service was performed.
 - This exclusion includes, but is not limited to:
 - Follow-up Physician and/or Surgeon visits;
 - Diagnostic tests which are primarily related to (or only necessary because) of a noncovered procedure or service;
 - Services to treat or resolve complications caused by a noncovered procedure or service;
 - Services or procedures to repair a failed noncovered procedure or service;
 - Services to repair scarring caused by a noncovered procedure, service or surgery;
 - Home health care required as a result of a noncovered procedure or service.
 - This exclusion does not apply when reimbursement is otherwise required by law.
- Charges related to the supervision of laboratory services that do not involve written consultation by a Health Care Practitioner including, but not limited to, laboratory interpretation.

Services, Treatments and/or Supplies

- Charges for which Our liability cannot be determined because a Covered Person, Health Care Practitioner, facility or other individual or entity within 30 days of Our request, failed to:
 - Authorize the release of all medical records to Us and other information We requested.
 - Provide Us with information We requested about pending Claims or other insurance coverage.
- Legal Services.
- Copying and providing medical or any other type of information in support of a Claim.
- Prescription Drugs and medications for Members who are eligible to enroll in the Medicare Part D program, regardless of whether they enroll. This exclusion does not apply to the following individuals, or in the following situations:
 - Employees who are actively at work, and their covered Dependents.
 - Members who are covered by our standard Family plan.
 - Members who are covered under state or federal continuation (COBRA) coverage, unless they choose to waive Prescription Drug coverage under this Policy.
 - Any Member for whom we are the primary payer according to Medicare Secondary Payer rules.

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- Any Prescription Drugs or medications that we are required by law to cover for all Members, including Members who are eligible to enroll in the Medicare Part D program.
- Services or items that are provided for free or for which you are not legally obligated to pay if you don't have insurance.
- Services that a child's school is legally obligated to provide. This exclusion applies regardless of whether the school actually provides the services, and whether you choose to use those services.
- Unless we are required by law to pay for them, services or items furnished or paid for by a governmental entity, facility, or program other than Medicaid.
- Services or items required by a third party. This includes, but is not limited to, services required for the purposes of insurance, employment or special licensing.
- Court-ordered treatment, unless:
 - It meets our criteria for Medical Necessity, Medical Appropriateness and Cost-Effectiveness;
 - It is otherwise covered under this Policy; or
 - We are required by law to cover it.
- Services or treatment for a medical condition that arose from, or originated during, service in the armed forces.
- Services or treatment for an Injury or Illness that resulted from participation in a crime.
- Non-emergency services you receive while you are outside the United States.
- Services ordered, directed, performed or provided to you by an Immediate Family member.
- Services or treatment eligible for worker's compensation benefits, or benefits from any other payment program established by a similar law.
 - This exclusion applies whether you apply for or receive worker's compensation or similar benefits.
 - This includes amounts received when a Claim under worker's compensation or similar law is settled by stipulation or compromise.

Charges and Expenses

- Travel and lodging.
- Charges or costs exceeding a benefit maximum or Maximum Allowable Fee, where applicable.
- Charges or costs for services you received while you were not covered under this Policy.

[WEA Trust Group Plans Specific Benefit Provisions](#)

This section provides additional details about specific healthcare service provisions.

[State Health Plan General Exclusions and Limitations](#)

Please refer to the [State Health plan Uniform Benefit plan document](#)

[WEA-MedPlus General Exclusions and Limitations](#)

Please refer to the [WEA-MedPlus plan document](#)

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Membership

Each WEA Trust subscriber is given an identification card. This card indicates the subscriber's name, ID number, the participants covered under the subscriber's plan, group number and copayment amount. The member number consists of nine digits which ends with a two-digit person code. Person 01 is always assigned to the subscriber.

Please be advised that presentation of an identification card does not necessarily imply current coverage. To verify a member's eligibility with WEA Trust, please utilize Maddy, the Provider Portal <https://providerportal.weatrust.com> or call WEA Trust Customer Service Department at 800.279.4090.

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Sample ID Card

		Members: https://member.maddyportal.com 800.279.4000
Subscriber: John Member	Group #: 00000	Notify WEA Trust in advance of planned hospital admissions and within 72 hours following an emergency admission.
ID#: 000000000	Issued: 09/06/2019	
Network: Trust Preferred		Providers: https://provider.maddyportal.com 800.279.4090
Subscriber / Dependents:		Claims: WEA Trust, PO Box 211438, Eagan, MN 55121-3038
John Member	000000000-01	Chiro Claims: Magellan, 7805 Hudson Rd, #190, St. Paul, MN 55125
Jane Member	000000000-02	
Copays: NETWORK: PCP \$25 / SPEC \$50 NON-NETWORK: PCP \$50 / SPEC \$100 CONV CARE: \$0 UC: \$100 ER: \$250		Pharmacy: MedImpact 888.807.8106
		RXBIN: 003585 RXGRP: WEA01 RXPCN: ASPROD1
		 

1. Subscriber: Subscriber Name
2. ID#: Subscriber and Dependent(s) Number
3. Group#: Employer Group Number
4. Network: Provider Network
 - Chippewa Valley Network
 - IYC Medicare Plus
 - Mayo Clinic Health System
 - Northwest-Chippewa Valley Network
 - Northwest-Mayo Clinic Health System
 - SMP-Trust Preferred
 - State Plan East
 - Trust East
 - Trust Preferred
 - Trust Select-Aurora
 - WEA-MedPlus
5. Issued: Date the Member ID card was Issued
6. Subscriber/Dependents: Member Name(s)
7. Insurance ID number and Person Code
8. Copays:
 - Network: Network Office Visit
 - Non-Network: Non-Network Office Visit
 - PCP: Primary Care Doctor
 - SPEC: Specialist
 - CONV CARE: Convenient Care Clinic
 - UC: Urgent Care
 - ER: Emergency Room

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Member's Rights and Responsibilities

Member Rights

- To receive courteous, sensitive, friendly service
- To be treated with respect and dignity
- To have privacy and confidentiality of your personal health information and records in accordance with state and Federal laws and our privacy policies
- To obtain the information you need to help you get the most from your health plan including information about our services, provider network, information about your healthcare, and how your health plan works
- To be informed about your health problems and to receive information about treatment options and their risk in order to make an informed choice
- To file a complaint or an appeal about your health plan, care that you receive, or any covered service or benefit determinations

Member Responsibilities

- To provide accurate and complete personal information about eligibility and enrollment, and correct information about other health insurance benefits. To read available member material, know your health plan benefits and requirements, and ask for help if you need it
- To follow all healthcare plan rules and policies
- To treat all health plan and healthcare professionals with courtesy and respect
- To ask questions about your condition, your treatment plan, and how to manage your health
- To follow the care plan that you agree on with your healthcare providers

Formal Complaints and Requests

Standard Grievance

Situations may occasionally arise when a participant is dissatisfied with some aspect of her/his health plan. WEA Trust health policies provide you with certain rights to seek a resolution of your complaint. If you are dissatisfied with a decision or an administrative service provided by WEA Trust, you should contact one of our Dispute Resolution Specialists at 800.279.4000 or 608.276.4000 (Voice/TTY). The Dispute Resolution Specialist will investigate your complaint and provide you with all the necessary information you need to pursue your grievance rights.

What is a Grievance?

A grievance is any dissatisfaction with our administration of your plan, with our claims practices, or with the services you have received from one of your providers, that is expressed in writing. For example:

- You believe you have not received the reimbursement that the policy promises
- You believe you have been denied coverage promised by the policy
- You are dissatisfied with covered services you received from one of our providers
- You believe your coverage has been unfairly terminated

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What is the grievance procedure?

In order to submit a standard grievance, you, or your authorized representative must submit the grievance to us in writing at this address: Ombudsperson, WEA Trust, P.O. Box 21538, Eagan, MN 55121. Your written grievance may be submitted in any form, but should include the following information:

- The insurance subscriber's name and identification number
- Information your complaint is about (dates, events, and the names of the providers involved.)
- The reason you are not satisfied
- Information to support your complaint (dates, events, and the names of the providers involved.)
- Copies of documents that support your complaint, such as the policy language specific to your concern that supports your request, medical records, etc.
- The solution you want.

We will confirm, in writing, that we received your complaint within five business days of receiving it. Within 30 calendar days, a Grievance Committee (three or more people) will review your complaint. If possible, one person will be a health plan member who is not a NeuGen employee. One person will be a NeuGen employee who can follow the Grievance Committee's instructions for a solution. We will tell you when and where the Grievance Committee will meet at least seven days beforehand. You (or an authorized representative) may come or call into the meeting. You may present information, ask questions, and submit written requests during the meeting. If new material is submitted at the meeting that requires a medical necessity determination, the Committee's decision may be delayed until the new material is reviewed.

If we cannot make a decision within the 30-day time limit, we may extend the limit an additional 30 calendar days. We will inform you in writing of the reason for the extension and the date by which the decision may be expected.

The Committee will review your grievance and make a decision. The responsibility of the Committee is to determine if WEA Trust has properly applied the provisions of the health plan to your claims. If the Committee believes that WEA Trust has not reasonably handled your dissatisfaction in light of the insurance policy and the known facts, it will issue instructions for corrective action. You will receive the Committee's decision in writing shortly after the grievance meeting. You will receive information about your right to an independent external review (IER) if your dispute qualifies for review by an independent review organization (IRO). You must notify us of your request for IER within four months of the date of the Grievance Committee's decision letter, or we will not consider your request for IER.

What is the procedure for an Expedited Grievance?

You can submit an expedited grievance if **any** if the following are true:

- Your life or health will be at serious risk if you have to wait for the standard grievance process.
- Your physician believes you will be in severe pain if you have to wait for the standard grievance process. The pain cannot be managed without the treatment listed in your grievance.
- Your physician decides it is necessary.

If any of the above pertain to your situation, please:

Call our Dispute Resolution Specialist at the number noted above to report your complaint immediately. You, your authorized representative, or your physician may call. An Ombudsperson will investigate and call you within 72 hours to tell you our decision. WEA Trust will also send you a written confirmation of the decision.

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Fact Sheet on the Independent Review Process

This fact sheet provides general information on the independent review process. If you have specific questions on how it may apply to your situation, please contact us. As with any other product or service, you may someday have questions or complaints about your health insurance plan. You may be able to resolve a complaint by contacting our Customer Service Department. You can also file a written grievance with us. All insurance companies offering health benefit plans are required to have an internal grievance process to resolve any complaint you may have with the plan. You may, at any time, contact the Office of the Commissioner of Insurance (OCI) with your question or problem at 608.266.3585 or 800.236.8517; or by writing to OCI at P.O. Box 7873, Madison, WI 53707-7873; or by e-mail at <http://oci.wi.gov>. If you are not satisfied with the outcome of your grievance, the law provides you with an additional way to resolve some disputes involving medical decisions. In those cases, you or your authorized representative may request that an Independent Review Organization (IRO) review our decision.

What is an independent review?

The independent review is a process that allows an outside expert to provide a second look at your claim. Because the reviewer is not affiliated with your health plan, the reviewer is able to conduct an independent and unbiased review of your claim. There is no cost to you. We will pay the cost of the reviewer's fee.

To qualify for an Independent External Review, **one** of the following must be true:

- You already submitted a standard grievance or expedited grievance that relates to a covered benefit which was denied to a determination that related to medical necessity, healthcare setting, medical appropriateness, level of care, or experimental treatment. You do not agree with our decision. *You may not request an independent review if the requested treatment is not a covered benefit. For example, if your policy specifically excludes coverage of weight loss treatment, your request for coverage of weight loss treatment would not be eligible for independent review, even if you believe that the treatment is medically necessary. However, you can ask us to review the denial decision through our internal grievance process. In addition, a complaint or grievance related to our administration of the plan is not eligible for independent review but may be grieved.*
- We (you and WEA Trust) agree to skip the standard grievance process and start an independent external review right away.
- An independent review organization thinks waiting for the standard grievance process might affect your health.

If any of the above pertain to your situation, please write to request an independent external review within four months of the Grievance Committee's decision letter. We will randomly choose an independent review organization (IRO) from a list of organizations that are certified by the Office of the Commissioner of Insurance. We will give information to the IRO within five business days after we receive your written request, including:

- All of the information you sent us to support your claim.
- All information (including health plan documents) we used to make our decisions.

The IRO has 45 days calendar days after receiving the information to write to you (and us) with their decision. **This decision is final.**

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What if I have more questions?

Our Dispute Resolution Specialist should be able to answer any questions you may have regarding the independent review process. You may also contact OCI at the address, phone number, or electronic mail address above.

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Physician Services/Plan Providers

Physician Services

WEA Trust is structured as a network model Preferred Provider Organization (PPO) health plan, which contracts with large multispecialty groups and independent practice physicians within the state of Wisconsin.

WEA Trust provider network includes more than 35,700 providers serving the state of Wisconsin:

- 17,300 physicians
- 147 hospitals

Our online provider directory is located under “*Find a Doctor*” on our website at www.weatrust.com.

Role of the Primary Care Physician

Definition

The Primary Care Physician (PCP) is the provider responsible for managing the healthcare of his/her members. Primary Care Physicians include Family Practice, Internal Medicine, Pediatrics, and in some cases OBGYN. When a PCP determines that care should be rendered by a specialty provider or other provider of service, the PCP will assist the member with coordinating services.

Status and Demographic Changes

PCP’s who wish to change their status with regard to accepting patients may do so with written notification to WEA Trust. Written notification must also be sent when a provider moves, adds a new location, or leaves practice. Changes should be sent to the Provider Network Management department using the [Provider Update Form](#).

Availability

It is the PCP’s responsibility to have in place effective procedures to provide for the availability and accessibility of medically necessary care 24 hours a day, 7 days a week.

Responsibilities

- Establish member eligibility and benefit coverage
- Provide care that is respectful of and responsive to individual patient preferences, needs, and values; and ensuring that patient values guide all clinical decisions
- Ensure that requested hospitals and referral physicians are participating providers
- Evaluate medical necessity, proposed place of treatment and treatment plan

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- Review and confirm the specialist treatment plan
- When necessary and appropriate, coordinate transfer of members both into and within the network of participating providers and hospitals
- Cooperate and coordinate with the WEA Trust Case Management Programs and Preauthorization Policies and Procedures
- Provide information to and cooperate with WEA Trust to facilitate coverage decisions

Role of the Specialist

Definition

The specialist and PCP should work together to coordinate the best care for the member.

Demographic Change

Written notification must also be sent to WEA Trust when a provider moves, adds a new location, or leaves practice. Changes should be sent to the Provider Network Management department using the [Provider Update Form](#).

Responsibilities

The specialist should remember the following:

- Verify that preauthorization has been obtained before rendering services, if required.
- Services rendered without preauthorization will result in a denied claim.
- The specialist should always verify member's eligibility before rendering service.
- WEA Trust advises the specialist maintain continuity of care with the PCP.

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Privacy and Security Policy

WEA Trust treats all sensitive information (including protected health information (PHI) and electronic PHI) as confidential in accordance with all applicable state and federal laws and regulations. WEA Trust recognizes the sensitive nature of the information gathered and developed in business operations, such as:

- Member-specific protected health information, including confirmation or acknowledgement that treatment or care management records may exist.
- Provider information related to quantity or quality of a provider's performance or to a provider's interactions in providing services to members.

WEA Trust recognizes members have a basic right to privacy of their personal information and records. WEA Trust honors members' privacy unless waived by the member as required by law. When information is disclosed, it is limited to what is minimally necessary to fulfill the immediate and specific purpose. All requests for release of information are responded to in accordance to WEA Insurance Corporation policy.

WEA Trust distributes its privacy notice to all members. To obtain a copy of the privacy notice, visit weatrust.com.

WEA Trust provides training to all workforce members on their responsibilities regarding confidential information. All workforce members sign a confidentiality acknowledgement at the time of engagement as well as an annual attestation that they have read, understand, and abide by all confidentiality policies.

WEA Trust requires all of its participating providers to treat member medical records and other protected health information as confidential and to assure the use, maintenance, and disclosure of such protected health information complies with all applicable state and federal laws governing the security and privacy of medical records and other protected health information.

Nondiscrimination Policy

WEA Trust will not discriminate against any applicant for participation in its plans or networks on the basis of race, gender, color, creed, religion, national origin, ancestry, or ethnicity, sexual orientation, age, military service, marital status, or any unlawful basis not specifically mentioned herein. Additionally, WEA Trust will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions.

Providers must meet predetermined criteria related to professional conduct and competence, as outlined in WEA Trust's credentialing program policies to be considered eligible for provider network participation. Applicants must complete a standard credentialing application which collects information regarding training, licensure, professional practice history, and other related qualifications. Applicants may be required to supply additional information or documentation when such evidence is reasonably necessary to determine whether the applicant will render services in a manner consistent with prevailing standards for professional conduct and quality of care.

WEA TRUST PROVIDER MANUAL

Utilization Management

We work closely with members and providers by coordinating and integrating diverse aspects of care, which enables members to receive appropriate, cost-effective, quality medical care. We perform utilization management internally and assist in controlling healthcare costs by negotiating preferential prices for healthcare providers, performing medical reviews to make sure members get needed services from the best quality, most efficient providers, and using evidence-based medicine to determine which treatment plan will provide the best outcomes at the best price.

Utilization management in specialty pharmacy on the medical benefit side uses prior authorization criteria that ensures lower cost therapies are adhered to at a rate sufficient to be able to determine effectiveness or failure of these therapies before escalating to higher cost treatment options. Adequate adherence is required before coverage of a more expensive or more risk-prone treatment option is considered.

Utilization management is supported by the following resources and tools:

- Prest and Associates
- Internally developed medical policies and guidelines
- National Comprehensive Cancer Network® (NCCN) guidelines
- UpToDate® – an evidence-based decision support tool
- Contracted external physician review organizations
- Hayes®
- MCG criteria® (formally known as Milliman Care Guidelines)

WEA Trust also creates internal medical policies and procedures for certain services. These policies are coverage guidelines that assess the medical necessity of a service or the medical appropriateness of the service based on the existing medical peer reviewed literature and/or the best available expert consensus. Policies are approved by the WEA Medical Policy Committee. Policies are reviewed and, if needed, updated on an annual basis.

WEA Trust medical policies are created using the following principles using evidence-based medicine:

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

Any utilization management request that does not meet established criteria for medical necessity and/or medical appropriateness, is reviewed by a physician before a denial is issued.

Chiropractic Medicine

Chiropractic services do not require preauthorization; however, services should be submitted to [Magellan Healthcare](#) for processing. Magellan Healthcare provides medical management services on behalf of WEA Trust. Magellan Healthcare reviews services to determine medical necessity.

WEA TRUST PROVIDER MANUAL

Never Events

In order to promote patient safety and quality care, WEA Trust follows the Centers for Medicare and Medicaid Services (CMS) guidelines in the matters of hospital-acquired conditions and [never events](#). CMS no longer reimburses surgical or other invasive procedures for the treatment of medical conditions when such procedures are performed in error by a practitioner or group of practitioners. As a result of the CMS' decision, WEA Trust will not pay for never events.

- **Performing a different procedure altogether**
A surgical or invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for the patient.
- **Performing the correct procedure on the wrong body part**
A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for the patient. This includes surgery on the appropriate body part, but in the wrong place, for example, operating on the left arm versus the right or on the left kidney not the right, or at the wrong level (spine).
- **Performing the correct procedure on the wrong patient**
A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.

Related Services

All related services provided during the same hospitalization in which the error occurred are not covered for either CMS or WEA Trust. We also do not cover other services related to these noncovered procedures as defined in the Medicare Benefit Policy Manual (BPM):

- All services provided in the operating room when such an error occurs are considered related.
- All providers who could bill individually for their services and who are in the operating room when the error takes place are not eligible for payment.
- Related services do not include performance of the correct procedure after the never event has occurred.

Preventable Adverse Events

WEA Trust follows the National Quality Forum (NQF) standards when defining adverse events. These events are:

- Adverse
- Indicative of a problem in a healthcare facility's systems
- Important for public credibility or public accountability

For a list of serious reportable events, please refer to the following website:

<https://www.ncbi.nlm.nih.gov/books/NBK20598/table/A7707/?report=objectonly>

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Harmony Care Management

Harmony Care Management takes Utilization Management (UM) review, Complex Care Management, and Disease Management to a new level of service. Our member-centric approach pairs each member with their own team of personal clinicians partnered together in care. The Harmony Care clinician will support the member throughout the continuum of care. WEA Trust believes this member-centric approach helps develop a relationship that builds coordinated care where patients are more informed on healthcare choices and are able to work with their doctors to find the best path of care. We believe it is our responsibility to help provide this education and support to our members. We partner with providers to find not just a solution to a member's need, but the best healthcare solution. Improving the health and well-being of all of our members every day, is in all we do at WEA Trust. Our Harmony Care management program focuses on the person inside the patient to deliver customized care programs and is provided by the staff at WEA Trust.

Our programs monitor, evaluate, and coordinate the healthcare process for members with complex diagnoses involving multiple chronic conditions, catastrophic injuries or illnesses, and cancer. The program provides coordination of care and focus on the immediate needs in order to control healthcare resource consumption, unnecessary complications, and improve clinical outcomes.

We reach out to members with specific high cost conditions or utilization patterns such as:

- Cancer
- Complex health conditions such as migraines, rheumatoid arthritis, stroke, COPD, heart failure and diabetes.
- Multiple emergency room visits, multiple inpatient stays, high costs care on specialty medications
- Traumatic accidents or injury
- Transplants
- Low back pain

Strategies Harmony Care clinicians take:

- Identify need for review of medications with our clinical pharmacist related to conflicts, concerns, improvement and opportunities.
- Converse with members before and after surgical interventions providing additional resources for successful rehabilitation.
- Coordinate efforts of/communication between multiple providers.
- Strategize with members after inpatients stays to provide education and coordination of resources.
- Provide evidence-based information, treatment options, and treatment outcomes for decision making.
- Discuss signs/symptoms of complications and develop a plan on how to respond if necessary.
- Discuss follow-up plan/appointments with their physician(s).
- Identify and coordinate resources that may be necessary for our members to remain safe and healthy in their homes.

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Clinical Quality Improvement

Quality Program

The purpose of the clinical quality improvement program at WEA Trust is to identify and improve healthcare, health status, and health functions which are important to the members of WEA Trust. This includes creating quality initiatives and goals, as well as drive programs that assist our membership in getting the highest quality and value in care, while keeping our members safe. These initiatives are aligned with the corporate mission, vision valued and critical success factors. Annually, specific goals are set based on the enterprise business plan, Healthcare Effectiveness Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results, and medical and utilization trends based on a variety of different data tools.

Reporting Quality and Satisfaction Results

Annually, WEA Trust measures and evaluates results using the HEDIS, which is a tool used by the majority of America's health plans to measure the performance on important dimensions of healthcare and service. These measures are specific around important health issues and allows us to better understand our member health population and provider performance in a variety of areas. In addition, WEA Trust assesses member satisfaction with their healthcare provider and system through the CAHPS survey. With this information, we are able to better direct our quality improvement efforts and collaborate with our providers and systems around areas where there are improvement opportunities.

Objectives

The following objectives are what drives the quality initiatives as they relate to quality of care, quality of service and member (patient) safety.

Identify and Improve Healthcare

WEA Trust offers member-centric care management and population health programs aimed at managing the health status of members. This includes medical management, shared decision making, chronic disease management, pharmacy management, patient safety and health promotion and wellness programs. Members at risk are proactively identified from a variety of data sources.

Program interventions include:

- Self-management education for chronic disease management and Shared Decision Making
- Member-centric Care Management
- Member Care reminders
- Provider outreach around gaps in care and poor medication adherence
- Member outreach around under/over utilization of services
- Complaint and grievance data
- Innovative high touch diabetes specific disease management program
- Telehealth and promotion through tailored outreach
- Innovative low back pain management program
- Oncology Program
 - WEA Trust works with Interlink CancerCARE to ensure our members receive evidence-based care that provides members with the best outcomes.

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- The Oncology Coverage Policy is available on our website at [weatrust.com/Providers/Medical Policies](http://weatrust.com/Providers/Medical_Policies).

Patient Safety

WEA Trust addresses patient safety issues in the following ways:

- Identifying potential clinical care issues via concurrent inpatient and outpatient review of services requiring preauthorization by WEA Trust's registered nurses.
- Providing transition of care and case management to members that ensure that care is received in a timely manner and member understands care plan.
- Providing Shared Decision Making resources and discussions to members so that they receive the care that they prefer and ensure the best possible quality outcome.
- Director of Clinical Pharmacy monitors drug interactions/contraindications/ and poor adherence patterns and educates member and providers.

Vitality

WEA Trust offers 24/7 access to an on-line personal health management suite, called Vitality, to all members ages 18 and older. This offering includes comprehensive health risk assessment, individualized action plan for health status improvement, and lifestyle and condition management programs. Incentives are available with participation.

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Preauthorization of Procedures

Preauthorization Definition

Preauthorization is the process of obtaining WEA Trust's authorization *prior* to the member receiving services. The purpose of the preauthorization function is for WEA Trust to determine member eligibility, benefit coverage, medical necessity, and appropriateness of services. Failure to receive preauthorization from WEA Trust for the services listed below will result in coverage being denied. Approval is not a guarantee of payment and is subject to all other policy limits and provision.

Required Clinical Information for Preauthorization

All preauthorization requests must be submitted with supporting clinical documentation that is relevant to the request.

Services Requiring Preauthorization

Please refer to www.weatrust.com/provider/preauthorization for the most recent Preauthorization List.

Note: This list may change. If you have further questions on what services require preauthorization you can contact our Provider Service Department at 800.279.4090.

Turnaround Time for Preauthorization

Urgent reviews: A decision is made within 72 hours.

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

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

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

Online Preauthorization Request

For your convenience, you may use our online preauthorization form located on our Provider Portal. If you don't have Portal Account access you can register by utilizing the following link:

www.weatrust.com/Providers

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Rehabilitation Medicine

Physical, speech, and occupational therapy services, excluding initial evaluation, requires preauthorization through [Magellan Healthcare](#).

Ineligible Durable Medical Equipment List

Please refer to www.weatrust.com/provider/preauthorization/ineligible-durable-medical-equipment-list for the most recent Ineligible Durable Medical Equipment list. **Note:** this list may change.

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Emergency Care/Urgent Care

Emergency Care

Emergency care means services provided in an emergency facility for a bodily injury or sickness manifesting itself by acute symptoms of sufficient severity (including severity of pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily organ or part
- Significant change for the worse without immediate medical or surgical treatment

Emergency care does not mean services for the convenience for the covered person or the provider of treatment or services.

Some examples of medical emergencies include:

- Suspected heart attack
- Loss of consciousness
- Suspected or actual poisoning
- Acute appendicitis
- Convulsions
- Heat exhaustion
- Uncontrollable bleeding
- Fractures
- Other acute conditions that are of sufficient severity to warrant immediate medical care

These are examples of conditions that are not medical emergencies:

- Ordinary sprains
- Cuts that do not require stitches
- Earaches
- Colds

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WEA Trust reimburses for the use of hospital emergency facilities only if an emergency room is required for obtaining covered services. If services provided could have been delivered safely and effectively in a less costly setting, or if the services are not covered services, then we do not reimburse for the emergency room.

Preauthorization is not required for the treatment of covered emergency services. However, if an individual is hospitalized overnight due to an emergency admission, the individual, family member, or medical provider must notify WEA Trust within 72 hours of admission or as soon as medically feasible. This notification applies for maternity-related emergency admissions as well, such as admission for pre-term labor or other maternity complications when childbirth does not occur. If WEA Trust does not receive the required admission notification, our reimbursement will be reduced by 50%, up to a maximum of \$250.

The copayment amount for services received in an emergency room is waived if an individual is admitted as an inpatient for at least 24 hours as a result of the medical emergency.

Emergency Hospital Admissions

Inpatient admissions to the hospital for an emergency, notify WEA Trust within 72 hours following the emergency.

Urgent Care

Urgent care is treatment for a condition that requires prompt attention, but does not pose an immediate, serious health threat. Such conditions require medical attention within hours rather than days in order to avoid complications or undue suffering. An example of a condition that might require urgent care is a urinary tract infection that, left untreated over a weekend, would cause an individual substantial distress and could progress to a widespread infection or kidney damage.

For a complete listing of participating hospitals, emergency rooms and urgent care facilities, use the *Find-A-Doc* function on our website at www.weatrust.com

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Pharmacy Services

Pharmacy Services Department

The primary goal of the Pharmacy Services Department is to strive for the appropriate, safe and cost effective drug therapy for all members.

Pharmacy Benefit Manager – MedImpact 888.807.8106

Our Pharmacy Benefit Manager (PBM) is MedImpact, which processes prescription drug claims submitted by retail, home delivery, or specialty pharmacies for WEA Trust members with our drug coverage. While State Plan members have health plan coverage with WEA Trust, their drug coverage is with another PBM, Navitus.

Our members have access to the MedImpact Pharmacy Network which includes nearly all the 66,700 pharmacies nationwide, approximately 1,200 of those in Wisconsin. The pharmacy network includes all retail chain pharmacies and nearly all independent retail pharmacies.

Home Delivery – MedImpact Direct Mail 855.873.8739

Our home delivery service is with MedImpact Direct Mail. The home delivery service allows members to obtain up to a 90-day supply of most medications at a lower copay/cost than at retail.

Specialty Pharmacy – MedImpact Direct Specialty 877.391.1103

Our specialty pharmacy is MedImpact Direct Specialty. Specialty medications are used to treat patients with chronic, serious health conditions. These drugs are both complex and expensive, and typically need special storage and handling. Specialty medications are also subject to preauthorization or step therapy. MedImpact Direct Specialty is our coordinator of specialty pharmacy services bringing the best performing specialty pharmacies into one product offering to meet the special needs of our members.

Drug Formulary

WEA Trust's drug formulary is the same for all members that have prescription drug coverage. Benefits will vary, but the formulary is the same. Most benefit designs place drugs into one of three categories:

- Tier 1 - Generic Drugs (lowest copayment)
- Tier 2 - Preferred Brands and High-Cost Generics
- Tier 3 - All Other Drugs (highest copayment)
- Tire 4 - Coinsurance for Specialty Drugs (used by employer groups who have chosen this plan design)

Value Drugs

We have a select list of value drugs which are available at \$0 cost or low out of pocket (high deductible plans). copay to most members. These value drugs are the most cost-effective medications in their class. Our list of value drugs can be found on our website at www.weatrust.com/members/drug-plan-information.

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Note: This list may change. If you have further questions regarding value drugs you should contact our Provider Service Department at 800.279.4090.

We also cover the following services at no cost when obtained from any network pharmacy and processed under the drug plan (non-State Plan members only): Flu shots, pneumonia vaccinations, shingles vaccinations (age dependent), and many contraceptives.

We cover the following medications at no cost for members age 40-75:

Atorvastatin (Lipitor) 10mg, 20mg | Fluvastatin (Lescol) 20mg, 40mg | Fluvastatin ER (Lescol XL) 80mg | Lovastatin (Mevacor) 10mg, 20mg, 40mg | Lovastatin ER (Altoprev) 20mg, 40mg, 60mg | Pitavastatin (Livalo) 1mg, 2mg, 4mg | Pravastatin (Pravachol) 10mg, 20mg, 40mg, 80mg | Rosuvastatin (Crestor) 5mg, 10mg | Simvastatin (Zocor) 5mg, 10mg, 20mg, 40mg.

Prescription Drug Preauthorization

WEA Trust requires preauthorization for certain prescription drugs. Depending on the drug, either MedImpact or WEA Trust will handle preauthorization. Our list of prescription drugs that require preauthorization can be found on our website at www.weatrust.com/provider/preauthorization.

Specialty Drug Preauthorization

WEA Trust requires preauthorization for medically administered specialty drugs. Archimedes or WEA Trust will handle preauthorization. Our list of specialty drugs that require preauthorization can be found on our website at www.weatrust.com/provider/preauthorization.

If you have further questions on what prescription drugs require preauthorization you should contact our Provider Service Department at 800.279.4090.

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Claim Requirements and Information

Clean Claim Data Elements

To ensure timely and accurate payments, it is extremely important for you to obtain the patient's current insurance information. It is your responsibility to submit a Clean Claim. A clean claim, whether submitted on a UB-04 or CMS-1500 form, must be consistent with CMS claim filing requirements and contain all of the following data elements:

- Insured name, address, WEA Trust assigned insured ID number (subscriber ID) and group number of the insured
- Patient name, address, date of birth and WEA Trust assigned patient ID number (do NOT submit the patient Social Security Number)
- Name of primary insurance, if other than WEA Trust
- Date of service
- Place of service or Type of bill
- Revenue and/or CPT/HCPC code
 - All outpatient hospital UB-04 requires submission of corresponding CPT/HCPC code with the revenue code.
- Include anesthesia minutes when applicable
- Rendering practitioner's name and NPI number when appropriate
- Payment name, address, telephone number, Federal Tax ID number, and National Provider Identifier (NPI) number

Electronic Claims Submission

WEA Trust prefers that claims be submitted through Electronic Claims Submission (EDI). EDI allows medical providers to send and receive healthcare claims information. If you submit electronically, you have agreed to do so in an electronic format that meets HIPAA compliance transaction and code set requirements.

EDI Transaction Sets:

ACH/NACHA – Electronic Fund Transfer (enrollment through clearinghouse is required)

270/271 – Real Time Eligibility

276/277 – Claim Status Response

835 – Remittance File (enrollment through clearinghouse is required)

837I – Institutional Claim File

837P – Professional Claim File

WEA Trust's clearing house is Netwerkes/Optum. WEA Trust's Payor ID is 39151. We are listed in some clearing houses as WEA and as Wisconsin Education Association in others.

When submitting medical claims, please remember the following:

- Based on the date of service, use current and appropriate HIPAA transaction and code set requirements
- WEA Trust does accept COB claims electronically
- Submit claims per the 5010 HIPAA implementation guidelines

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- Claims may be rejected when submitted with invalid or missing information such as Unspecified Laterality Diagnosis codes. These claims will appear in the 277CA report with the following rejection codes:

A7 - Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected

772 - The greatest level diagnosis code specificity is required.

Coding Requirement Guidelines

WEA Trust follows industry standards relating to coding and billing:

- Healthcare Common Procedure Coding System (HCPCS) for procedures/ancillary services
- Current Procedural Terminology (CPT) for physician procedures
- International Classification of Diseases (ICD-10) for diagnosis and hospital inpatient procedures
- Codes maintained by the National Uniform Billing Committee (NUBC) for institutional use
- National Provider Identifier (NPI)
- Taxonomy
- Specified Laterality Diagnosis Codes

All codes billed must be appropriate and active for the specific date of service billed.

WEA Trust utilizes clinical edit software to automatically review claim submissions for appropriate claim coding. This includes edits for:

- Procedures that are age-specific
- Gender-specific
- Bundling/unbundling
- Global billing and follow-up services other standard coding practices
- Procedures and guidelines such as those established in UB-04 and CMS's Medicare Database
- National Correct Coding Initiative (NCCI) and Medicare's rules
- Modifiers related to multiple and bilateral surgical procedures, assistant surgeons, co-surgeons
- Multiple scope procedures billed on the same day, same session
- Quality measures including but not limited to the guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors

Release of Information/Record Requests

Your Provider Agreement requires you to cooperate fully with reasonable requests from WEA Trust for relevant information related to the processing of claims. WEA Trust doesn't cover the cost of copying such records if those records are requested for purposes of adjudicating a claim or allowing WEA Trust to perform preauthorization that is required.

Coordination of Benefits

It is important for you to obtain appropriate information from the patient about other insurance coverage, including Medicare coverage. Follow Wisconsin's Coordination of Benefit rules and CMS's Medicare as Secondary Payer rules, including billing other insurers first when that is appropriate. WEA Trust will only reimburse you up to the Allowable Amount less the amount paid by the primary payer.

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Workers Compensation

We do not reimburse services eligible for workers compensation benefits. Providers may direct all worker's compensation claims to the member's applicable worker's compensation carrier.

Subrogation

The subrogation provision of WEA Trust benefit plans and provider contracts entitles WEA Trust to recover from a responsible third party when WEA Trust pays benefits on behalf of a member. Members and providers must cooperate to assist WEA Trust in protecting their subrogation rights. Subrogation efforts will not affect your reimbursement. The intent of subrogation is to secure a recovery from the party responsible for the injuries or illnesses of WEA Trust members. The provider is expected to advise WEA Trust of the existence of a potential third party when submitting a claim. WEA Trust uses Equian for recovery services, who may contact the provider for needed information.

Timely Filing

Submit claims within your contractual filing limit from the date of service or from the date of the primary insurance carrier's Explanation of Benefits (EOB).

Note: You may not bill the participant or WEA Trust for charges or claims that remain unpaid due solely to your untimely submission to WEA Trust.

Claim Reconsideration Process

Claim correction and reconsideration should be submitted by completing the Claim Resubmission form. The form can be found at providerportal.weatrust.com

The form can be filled out electronically through the provider portal, which is the preferred method by WEA Trust. Also, there is a fillable form available at weatrust.com under provider forms. This can be mailed to:

WEA Trust Insurance
Attn: Claims Resubmission Request
P.O. Box 211438
Eagan, MN 55121-3038

The form serves as the fax cover letter for all applicable claims. This form should be used for resubmitted claims only. Original claims should be submitted electronically or by mail.

Hold Harmless

As a Participating Provider, you have agreed to accept payment of the Allowable Amount as payment in full for the healthcare services performed. You may not charge, collect a deposit from, bill, or in any way seek compensation from a Participant for healthcare services rendered to the Participant. You are allowed to collect applicable copayments from the Participant at the time the services are provided, but you may not collect the coinsurance, deductibles, and charges for non-covered services directly from the Participant until you receive the remittance for the services.

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Claim Audits

WEA Trust claim payment integrity includes evaluation of the appropriateness of paid claims. We may conduct an audit of paid claims for institutional, professional and other types of providers who submit claims to WEA Trust. The results of these audits may require adjustment to payment and/or requests for reimbursement of paid claims.

Fraud, Waste, and Abuse

In order to promote high-quality, cost-effective care for our membership, WEA Trust maintains a comprehensive **Fraud, Waste, and Abuse** program to prevent, investigate, and report suspected healthcare fraud, waste, and abuse.

Fraud: “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Waste: Healthcare spending that can be eliminated without reducing the quality of care. Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity.

Abuse: “Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. (42 CFR § 455.2)

Modifiers Impacting Reimbursement

Below is a list of the most commonly billed modifiers and WEA’s Reimbursement Policies. Please be advised that this list is not all-inclusive:

Endoscopic Multiple Procedure Reduction: When multiple procedures are performed on the same day, patient encounter, and by the same provider a reduction in reimbursement is applied to the secondary or subsequent procedures. The secondary or subsequent procedures are reimbursed at 25% of the providers allowed amount.

Modifier	Description	WEA Reimbursement Policy
Modifier 21	Prolonged E&M service	No additional payment is allowed for service billed with this modifier.
Modifier 22	Increased Procedural Services	In all cases, medical record documentation must justify the substantial additional work and the reason for the additional work.
Modifier 24	An unrelated E&M service by the same physician during post-op period	Reimbursement considered independently from services in which they are not a component.

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Modifier	Description	WEA Reimbursement Policy
Modifier 25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional on the Same Day of the Procedure or Other Service	Reimbursement considered independently from services in which they are not a component.
Modifier 26	Professional Component	Allowance based on fee schedule/contracted rates.
Modifier 32	Mandated services	The member's benefit plan determines if mandated services are covered or excluded.
Modifier 33	Preventive Services	Informational modifier no additional reimbursement but used for quality metrics.
Modifier 50	Bilateral procedure—A procedure carried out on both sides of body	Reimbursement will be at 150%, subject to the provider contract rate.
Modifier 51	Multiple procedures—Many procedures carried out at the same time	Primary procedure reimbursed at 100% of the Allowed Amount. The remaining procedures that are subject to multiple surgery reductions will be reimbursed at 50% of allowed amount.
Modifier 52	Reduced Service	Reimbursement will be allowed at 50%, subject to the provider contracted terms.
Modifier 53	Discontinued Procedure	Reimbursement will be allowed at 50%, subject to the provider contracted terms.
Modifier 54	Surgical care only	When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at 70%, subject to provider contract terms.
Modifier 55	Post-op management only	When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at 20%, subject to provider contract terms.
Modifier 56	Pre-op management only	When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at 10%, subject to provider contract terms.

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Modifier	Description	WEA Reimbursement Policy
Modifier 57	Decision for surgery	E&M CPT codes (99201-99499) submitted with Modifier 57 are allowed separate from the reimbursement for the surgical procedure code if the documentation supports that the decision for surgery was made during the global preoperative period. Documentation required upon request.
Modifier 58	Staged/related procedure/service by the same physician during post-op period	Reimbursement for the primary procedure will be allowed at 100%, subject to the provider contract terms.
Modifier 59	Distinct Procedural Service	Reimbursement considered independently from services in which they are not a component.
Modifier 62	Two Surgeons	Reimbursement for co-surgeon will be paid at 62.5% of the allowed amount for each surgeon.
Modifier 73	Discontinued Procedure	Reimbursement for discontinued procedure prior to the administration of anesthesia at 50% of the Allowed Amount.
Modifier 74	Discontinued Procedure	Reimbursement for discontinued procedure after to the administration of anesthesia at 50% of the Allowed Amount.
Modifier 76	Repeat Procedure or Service by Same Physician or Other Qualified Healthcare Professional	Informational modifier no additional reimbursement.
Modifier 78	Return to operating room for related procedure during post-op period	Reimburse at 70% of the Allowed Amount.
Modifier 79	Unrelated procedure/service by same physician during post-op period	Reimbursement for unrelated services will be considered independently from services in which they are not a component.
Modifier 80	Assistant surgeon	MD assistant surgeon reimbursed at 25% of Allowed Amount. Non-MD assistant reimbursed at 15% of the Allowed Amount.
Modifier 81	Minimum assistant surgeon	MD assistant surgeon reimbursed at 25% of Allowed Amount. Non-MD assistant reimbursed at 15% of the Allowed Amount.
Modifier 82	Assistant surgeon when a qualified resident surgeon was unavailable	MD assistant surgeon reimbursed at 25% of Allowed Amount. Non-MD assistant reimbursed at 15% of Allowed Amount.
Modifier 90	Reference laboratory	Reimbursement based on provider's agreement with WEA.
Modifier 99	Multiple modifiers	Services requiring the use of multiple modifiers should be billed with all modifiers listed.
Modifier AA	Anesthesia services personally performed by anesthesiologist	100% of Allowed Amount.

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Modifier	Description	WEA Reimbursement Policy
Modifier AD	Medical supervision: more than 4 concurrent anesthesia procedures	50% of Allowed Amount. Total reimbursement will not exceed the Allowed Amount otherwise recognized had the service been furnished by the MD alone.
Modifier AS	Surgical Assistant	15% of the Allowed Amount.
Modifier QK	Medical direction of two, three or four concurrent anesthesia procedures	50% of Allowed Amount. Total reimbursement for CRNA and MD will not exceed the Allowed Amount otherwise recognized had the service been furnished by the MD alone.
Modifier QX	CRNA service with medical direction by an anesthesiologist	50% of Allowed Amount. Total reimbursement for CRNA and MD will not exceed the Allowed Amount otherwise recognized had the service been furnished by the MD alone.
Modifier QY	Medical direction of one CRNA/AA by an anesthesiologist	50% of allowed amount. Total reimbursement for CRNA and MD will not exceed the Allowed Amount otherwise recognized had the service been furnished by the MD alone.
Modifier QZ	CRNA/AA without medical direction by physician	100% of Allowed Amount.
Modifier P1	Physical Status–Normal Health Patient	100% of Allowed Amount.
Modifier P2	Physical Status–Patient with mild systemic disease	100% of Allowed Amount.
Modifier P3	Physical Status–Patient with severe systemic disease	100% of Allowed Amount.
Modifier P4	Physical Status–Patient with severe systemic disease that is constant threat to life	100% of Allowed Amount.
Modifier P5	Physical Status–Moribund patient who is not expected to survive without operation	100% of Allowed Amount.
Modifier P6	Physical Status–A declared brain-dead patient whose organs are being removed for donor purposes	100% of Allowed Amount.

Overpayments

WEA Trust's most common method of claim overpayment recovery is the automatic reduction of payment. This means that any amount owed to WEA Trust will be offset from future payments. All recoveries will be listed at the end of the Remittance Advice/Explanation of Payment.

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Credentialing Policies and Procedures

WEA Trust is committed to ensuring that our members have access to a network of trusted, high-quality healthcare providers. Credentialing is an important process WEA Trust uses to assess participating providers and applicants on the basis of their ability to deliver patient care consistent with prevailing quality of care standards. Providers must meet minimum standards for licensure, malpractice insurance coverage, and other relevant criteria to be eligible for participation in the WEA Trust provider network.

Provider network participation is contingent upon successful completion of the credentialing review process. All credentialing and recredentialing decisions are based on information supplied in the provider's credentialing application and/or obtained from a primary verification source. WEA Trust does not discriminate against applicants or make credentialing decisions based on the provider's race, ethnic/national identity, gender, age, sexual orientation, or type of patient in which the provider specializes.

Initial Credentialing

Contracted network providers must complete the credentialing process and receive approval for network participation prior to treating WEA Trust members. Services provided prior to the successful completion of this process will be denied and may not be billed to the member. Credentialing may be completed by WEA Trust Credentialing staff or through a formalized Credentialing Delegation Agreement with your provider group, system, or network.

When a new provider joins your organization, please complete and submit a [Provider Update Form](#), found on our website at weatrust.com. WEA Trust's credentialing staff will determine whether credentialing is required prior to enrolling the provider for network participation, and will contact your office as needed to begin the credentialing process.

Providers must meet the following criteria to be considered eligible for participation in a Trust provider network:

- a. Possess a current, valid license or other legal credential authorizing practice in each state in which the provider will be providing care to Trust members.
- b. Possess a current, valid Drug Enforcement Administration (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, as applicable to the provider's scope of practice. An individual provider to whom this standard applies must maintain a valid DEA/CDS for each state in which he/she will be providing care to Trust members. An initial applicant who has not yet received a required DEA/CDS registration may be deemed eligible for participation if he/she:
 - i. Can provide evidence that he/she has applied for a DEA/CDS registration;
 - ii. Has made an arrangement for an alternate practitioner to prescribe controlled substances until his/her own DEA/CDS is issued;
 - iii. AND, agrees to notify WEA Trust upon receipt of his/her DEA/CDS registration. Failure to provide proof of the appropriate DEA/CDS within 90 days of approval will be considered a failure to meet the standard for participation.
- c. Maintain malpractice insurance coverage as required by law.

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- d. Not be subject to current sanction, discipline, debarment or exclusion from participation in Medicare, Medicaid, Tricare, Federal Employees Health Benefits, or other government healthcare program.
- e. Submit a complete and accurate application and timely response to WEA Trust Credentialing staff's inquiries.

WEA Trust will credential a provider if we can reasonably conclude, upon review and consideration of all available information, that the provider will render services consistent with prevailing quality of care standards, and that the provider does not demonstrate a significant risk to the health and welfare of WEA Trust members. WEA Trust will consider the following criteria to determine whether a provider meets this standard, taking into consideration the provider's practice history including pattern and/or severity of reported incidents, restrictions imposed on the provider's practice, and harm to patients:

- a. Provider's license to practice in any jurisdiction has not been voluntarily or involuntarily limited, suspended, revoked, denied, disciplined, or subjected to probationary conditions, nor have proceedings been initiated toward these ends. Provider has not withdrawn an application for licensure in order to avoid a professional review or adverse decision.
- b. Provider has not been denied participation, membership or renewal thereof, nor been subject to any disciplinary action in any local, state, or national medical organization, governmental health-related program, or professional society, nor have proceedings been initiated toward any of these ends.
- c. Provider has not developed health impairments that could impact his/her ability to deliver medical care. If Provider has a history of one or more alcohol or drug-related incidents, he/she is compliant with any recommendations for assessment or treatment.
- d. Provider has not been convicted of a felony or misdemeanor which reasonably could be considered to impact a provider's ability to deliver medical care.
- e. Provider's medical staff membership or clinical privileges at any hospital or healthcare institution have not been limited, suspended, revoked, denied, not renewed, or subjected to probationary conditions; nor has an adverse action been recommended by a standing medical staff committee or governing board; nor has the provider withdrawn an application for appointment or reappointment in order to avoid a professional review or adverse decision.
- f. Provider's DEA or CDS registration has not been denied, revoked, suspended, reduced, or not renewed, nor have proceedings been initiated toward these ends.
- g. Provider's specialty board certification or eligibility has never been denied, revoked, relinquished, not renewed, suspended, nor have proceedings been initiated toward any of these ends.
- h. Provider has not been denied professional liability insurance nor had a policy canceled.
- i. Provider has not been found negligent in or settled a professional malpractice action that involved the death or substantial bodily injury of a patient.

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Recredentialing

WEA Trust requires participating providers to comply with periodic recredentialing to ensure that they continue to meet established standards. The recredentialing process includes reverification of the provider's licensure and professional liability insurance coverage, and evaluation of any member complaints or changes in the provider's health status, history of professional sanctions, and/or liability claims.

For those providers who participate in CAQH ProView, WEA Trust will obtain recredentialing materials directly from CAQH. Providers who choose not to participate in CAQH ProView will receive a pre-populated application from WEA Trust Credentialing staff in advance of the recredentialing due date. To maintain network participation, providers must complete and return the application and any supporting documents as needed to complete recredentialing within required time frames.

Ongoing Monitoring

WEA Trust performs ongoing review and monitoring to ensure participating providers maintain compliance with established credentialing standards, and may take action to exclude, suspend, or terminate a provider's network participation based on quality of care concerns, professional misconduct, or violation of WEA Trust policies or procedures.

Providers must notify WEA Trust within ten (10) calendar days of:

1. Any finding by a licensing or regulatory authority which imposes a censure, reprimand, probation, restriction, suspension, denial, or revocation of the provider's license, certification, accreditation, DEA and/or CDS registration, clinical privileges, or Medicare or Medical Assistance participation status.
2. Any investigation where the potential consequences of such investigation include involuntary suspension, termination, revocation, restriction or reduction of the provider's clinical privileges, license to practice, certification, accreditation, or DEA and/or CDS registration
3. Any voluntary surrender of a license while under scrutiny or to avoid scrutiny.
4. Any involuntary termination of a healthcare service contract.
5. Any adverse final judgment of a medical malpractice or other healthcare-related suit, action, or proceeding, including civil monetary penalties or injunctions.
6. Any conviction of a felony or misdemeanor which reasonably could be considered relevant to the provider's professional practice.

Credentialing Confidentiality

Information gathered for the purpose of provider credentialing is confidential. Access to credentialing information is limited to WEA Trust staff who perform, administer, direct, or provide oversight for the credentialing process. Credentialing information or documents will only be released to outside parties with permission of the provider involved or as permitted by law, including Wis. Stat. 146.38 and/or the Healthcare Quality Improvement Act of 1986.

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Provider Contract Provisions

Providers who participate in the WEA Trust Provider Network are independent and may be contracted with several health plans. This Provider Manual offers general guidance on our operating rules and procedures, Providers are encouraged to become familiar with the specific terms of their Provider Agreement with WEA Trust. Our policies and procedures are periodically reviewed and updated to reflect the constantly changing healthcare industry.

Provision of Services Policy

Provider shall establish effective procedures, including an appropriate call system if necessary, to provide for the availability and accessibility of medically necessary services 24 hours a day, seven days a week. Provider shall provide or arrange for the provision of covered services to members as promptly as reasonable, consistent with the professional standards for the community in which such services are provided.

Provider shall not utilize the services of any Provider who has not been contracted by WEA Trust.

Operating Rules and Procedures

Provider shall cooperate with and abide by the rules, regulations, programs, and procedures established from time to time by WEA Trust, including, but not limited to, quality assurance protocols, external and internal peer review programs, utilization control mechanisms, member grievance procedures, and credentialing and recredentialing procedures.

Provider Appeal Process

The provider appeal process is designed to provide appropriate and timely review when Providers and Facilities disagree with a decision made by WEA Trust.

WEA Trust strives to informally resolve issues raised by healthcare professionals on initial contact whenever possible. The provider appeal process is different from routine requests for follow-up inquiries on claim processing errors or missing claim information. Most claim issues can be remedied quickly by providing requested information or contacting us.

If issues cannot be resolved informally, WEA Trust offers an appeal process for providers for resolving disputes regarding post-service payment denials and payment or other disputes. All appeals must be submitted in writing within six months of the date of the initial payment or denial notice.

To submit an appeal, a provider should send a letter to:

WEA Insurance Corporation
ATTN: Provider Appeals–Heidi Folmer
PO BOX 21538
Eagan, MN 55121-5038

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To allow WEA Trust the opportunity to provide a full and thorough review, healthcare professionals should submit the following information with their appeal:

- Provider's name
- Contact information for provider including the name of the person submitting the appeal and the contact address
- WEA member/patient information—ID number and date of birth
- Date(s) of service
- Claim number, if available
- An explanation of why the provider believes the payment amount, request for additional information, request for reimbursement of claim overpayment, or other action WEA Trust took is considered incorrect
- Medical records (if a clinical appeal)

WEA Trust's Office of General Counsel will investigate the appeal and prepare a file with a summary of findings and any information submitted by the provider to support the appeal. Following the investigation, the Provider Appeals Committee will meet to review the file and render a decision.

The review will be completed in 75 days and the healthcare professional will receive the appeal determination in writing. If an appeal determination overturns the initial decision, claims will be reprocessed within 30 days.

Provider Network Management

The Provider Network Management Department is available to providers for in-office meetings and will come to the provider location to:

- Conduct new provider orientation
- Train office and support staff
- Resolve problem claim issues
- Provide new or changing information on policies or programs
- Discuss concerns
- Assist the provider office in any way possible with regard to WEA Trust's business

Provider Updates

As a current WEA Trust Network Provider, keeping your listing current and accurate is vital for members to locate you. To report any changes in your organization, practice, or practitioners, please use the [Provider Update Form](#).

Be sure to include the following information:

- Organization or business name
- Tax ID
- Billing or other contact information
- Practitioners joining or leaving your organization
- Practitioner name, specialty or credentials
- Service locations

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Return your completed Update Form via e-mail to: providerupdates@weatrust.com

Provider Network Contacts:

Tim Bartholow, M.D. – Chief Medical Officer	608.661.6646
Joe Weyer – Director of Provider Contracting and Network Management.....	608.661.6762
Traci Schaefer – Provider Relations Manager	608.661.6666
Lisa Richter – Provider Contract Manager.....	608.661.6603
Chris Auger – Provider Contract Manager.....	608.661.6754
Nora Moses – Manager of Credentialing	608.395.6311
Provider Service Phone Number	800.279.4090