WEA Trust Provider Manual 2017

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.

How To Contact WEA Trust

HOURS: Monday through Friday: 7:30 a.m. to 5:00 p.m.
Friday summer hours: 7:30 a.m. to 4:30 p.m. (Memorial Day through Labor Day)
Telephone**:** (800) 279-4090
Fax: (608) 276-9119

Correspondence Mailing Address:
WEA Trust
P.O. Box 7338
Madison, WI 53707-7338

Physical Address:
WEA Trust
45 Nob Hill Road
Madison, WI 53713
View map

Claims Mailing Address:
WEA Trust
P.O. Box 8220
Madison, WI 53708-8220

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.

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.

Essential Health

Essential Health is available to public school districts, and county and municipal employers. It provides comprehensive coverage based on the Essential Health Benefit requirements included in the Affordable Care Act. Groups have two network options; WEA Trust Preferred Network, a broad-based PPO network, and in the northwest, the Mayo Network is a more limited network option. Groups also have a variety of eligibility, cost-sharing and coverage options, as well as whether to purchase the product in its fully-insured or self-insured forms.

Essential Qualified (High Deductible HSA Qualified Plan)

Essential Qualified is also available to public school districts, and county and municipal employers and is designed to meet the federal requirements of a High Deductible Health Plan that can be matched with a Health Savings Account. In Essential Qualified the deductible is first in the order of cost-sharing applied to a claim and pharmacy costs also apply to the deductible. There are fewer options available under Essential Qualified, 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 services areas, covering most counties in the state. The service areas are the East, the Northwest, and South Central (Dane County). In the Northwest, employees have to select one of two networks; the Chippewa Valley Network or the Mayo 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.

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.

Delta Dental

~~Delta Dental purchased our dental block of business, with transition of all group business finalizing in 2015. While WEA Trust no longer provides dental coverage,~~ Delta is our preferred dental partner, and our Sales group promotes the close working relationship that we have. WEA Trust is also forging a further partnership with Delta to enhance dental benefits for members with certain chronic conditions.

Exclusions and Limitations

WEA Trust Group Plans General Exclusions
(Section 5 of Certificate of Coverage)

Depending on the member's plan, exclusions and limitations may include, but may not be limited to the following.

We do not reimburse expenses for, or in connection with, the following:

- Legal services.
- Missed appointments.
- Copying and providing medical or any other type of information in support of a claim.
- Travel and lodging.
- Experimental/Investigative treatments and services.
- Services rendered by a massage therapist.
- Weight control, weight loss, or the treatment of obesity, including, but not limited to, prescriptions, programs, and surgeries.

  Note: While we never reimburse for weight control, weight loss, or the treatment of obesity, we reimburse the following services, as required by law: comprehensive, intensive nutritional counseling by qualified providers for obese adults and adults at higher risk for diet-related chronic disease, and comprehensive, intensive nutritional counseling and behavioral interventions for obese children.
- Replacement of prescription drugs or medications, orthotics, prosthetics, or equipment that are lost, stolen, damaged, misplaced, missing, or otherwise compromised.
- Vocational rehabilitation, including work-hardening programs.
- Augmentative and/or alternative communicative devices and systems.
- Bariatric surgery, gastric restrictive or bypass procedures, or similar surgeries.
- Services for, or in connection with, or leading to, gender reassignment.

- Routine foot care except in cases where such foot care may pose a hazard for a patient with a recognized medical diagnosis, such as diabetes, peripheral neuropathies (as determined by WEA Trust), arteriosclerosis, or chronic thrombophlebitis. Routine foot care includes, but is not limited to, the treatment of corns, calluses, plantar keratosis, and nail trimming.

- Foot orthotics.

- Compression stockings.

- Tobacco cessation aids, except for specified prescription and over-the-counter aids as described in Section 6, “Tobacco Cessation Benefits.”

- Blood pressure cuffs.

- Non-wearable automated external defibrillator (AED).

- Cranial banding.

- Enuresis alarms.

- Appliances for snoring.

- Ultrasonic nebulizers.

- Private duty nursing services.

- Gene therapies, treatments, or enhancements.

  Note: While we never reimburse for gene therapies, treatments, or enhancements, we reimburse for genetic testing and/or genetic counseling as specifically provided under “Maternity and Newborn Benefits” in Section 6.

- Office visits, Physician charges, or any other service for, or in connection with, a procedure or service that this policy does not cover. This includes, but is not limited to, follow-up Physician and/or Surgeon visits, diagnostic tests necessary only or primarily because of the non-covered procedure, services to repair a failed procedure or service, services to repair scarring from services or surgery that this policy does not cover, and home health care required as a result of a non-covered procedure or service. This exclusion applies except where reimbursement is otherwise required by law.

- Equipment or services to prevent injury or to facilitate participation in physical activity or sports.

- Services to prevent illness, except for those expressly listed in Section 6 or that we are required by law to cover.
- Immunizations obtained solely for the purpose of traveling outside of the United States.

- Services or items for physical fitness, wellness, health education, vitamins, or personal hygiene.

- Nutritional or diet supplements, except for those that we are required by law to cover.

- Services to educate or help adapt to a diagnosis or a chronic physical or mental condition. Examples are stress management classes and education and awareness training for those suffering from chronic pain.

- Services to improve an existing physical or mental state in the absence of an illness or injury.

- Services to treat impotence and erectile dysfunction.

- Services to improve appearance. Examples are services to improve skin appearance, cosmetic surgery, and services to remove keloids or repair scarring or disfigurement resulting from body piercing, tattooing, implants, or other services or procedures that are not medically necessary or medically appropriate and/or were not performed by a licensed medical professional.

  Cosmetic surgery is elective surgery performed primarily to improve appearance. The procedure would provide little or no accompanying meaningful improvement in the functioning of a malformed body part or restoration of a bodily function.

- Services, drugs, and injections for male or female baldness or hair loss regardless of the cause, including hair restoration, hair transplants or hair implants.

- Services or supplies provided primarily for the convenience or personal preference of the patient, the physician, the patient's family, or any other person.

- Custodial or long term care. By this, we mean services that can generally be provided by persons without professional medical training or skills and that are primarily for one or more of the following purposes:
  - Maintaining an individual's existing physical or mental condition of health.
  - Preserving an individual's condition from further decline.
  - Assisting an individual in performing the activities of daily living, such as bathing, eating, dressing, toileting, and transferring.
  - Protecting an individual from threats to health and safety due to cognitive impairment.
  - Meeting an individual's personal needs.

  We consider such services to be custodial even if provided by registered nurses, licensed practical nurses, or other trained medical personnel.

- Services that continue after the patient reaches the expected state of improvement, resolution, or stabilization of a health condition.

- Holistic or homeopathic remedies and preparations.

- Services or interventions that, while they may be beneficial, have not been scientifically documented as safe and effective for a specific illness or injury. Examples include, but are not limited to, acupuncture, acupressure, guided imagery, meditation, Rolfing, reflexology, yoga, hypnosis, aromatherapy, relaxation techniques, herbal medicine, naturopathy, iridology, Ayurvedic medicine, and massage.

- Medical services that have not been proven in randomized clinical trials and recognized by contemporary medical consensus as being both safe and effective.

- Prescription drugs and medications for individuals who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except for:

  1. Employees who are actively at work and their covered dependents.
  2. Individuals who are covered by our standard family plan.

3. Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive prescription drug coverage under this plan.
4. Any individual for whom this plan is primary under Medicare Secondary Payer rules.

Prescription drugs and medications that we are required by law to cover are covered for all individuals, including those eligible to enroll in the Medicare Part D program.

- Services or items furnished free of charge or for which you are not legally obligated to pay in the absence of insurance.
- Services that a child's school is legally obligated to provide, whether or not the school actually provides them and whether or not you choose to use those services.
- Services or items furnished or paid for by a governmental entity, facility, or program other than Medicaid, unless we are required to do so by specific law.
- Services or items required by a third party. Examples are services required for insurance, employment, or special licensing purposes.
- Court-ordered treatment unless it meets our criteria for medical necessity, medical appropriateness, and cost-effectiveness, or is otherwise covered under the policy.
- Costs incurred while you are not covered by this policy.
- Care for a medical condition that arises from, or originates during, service in the armed forces.
- Non-emergency services you receive outside of the United States.
- Care for a medical condition resulting from participation in a crime.
- Services provided to you by a covered member of your family.
- Services eligible for worker's compensation benefits, or benefits from any other payment program established by similar law, whether or not you apply for or receive them. This includes amounts received when a claim under worker's compensation or similar law is settled by stipulation or compromise.

WEA Trust Group Plans Specific Benefit Provisions
(Section 6 of Certificate of Coverage)

This section provides additional details about specific health care 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

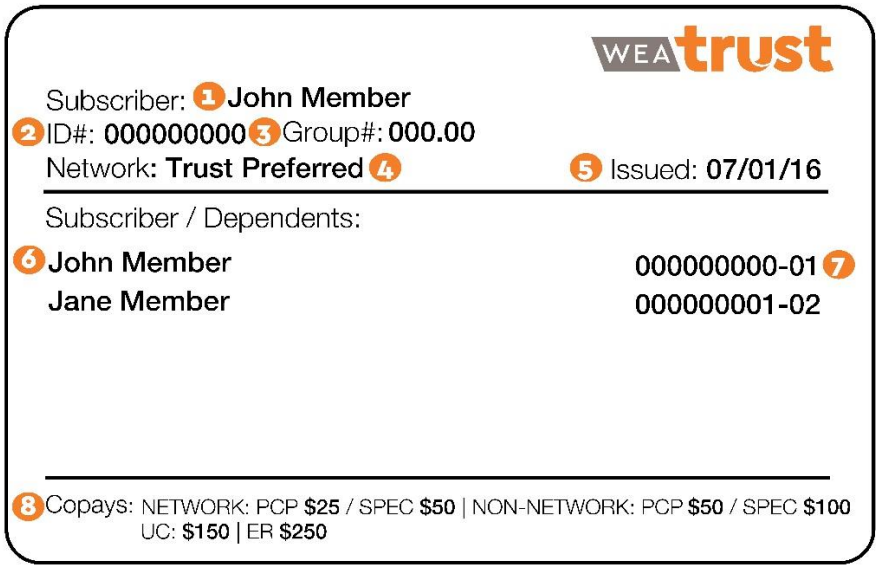
Please refer to the WEA-MedPlus plan document

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 the Provider Portal https://providerportal.weatrust.com or call WEA Trust Customer Service Department at (800) 279-4090.

Sample ID Card



1. Subscriber Name
2. Insurance ID number for subscriber and dependent(s)
3. Group Number
4. Network that the subscriber and dependent(s) are covered under
5. Date the ID card was issued to the subscriber and dependent(s)
6. Subscriber and Dependent(s) 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

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 health care, 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 health care plan rules and policies
- To treat all health plan and health care 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 health care providers

Member Grievance Process

Standard Health Plan Grievance

Situations may occasionally arise when a participant is dissatisfied with some aspect of her/his health plan. WEA Trust health and dental 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 Ombudspersons at (800) 279-4000 or (608) 276-4000 (Voice/TTY). The Ombudsperson 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

What is the grievance procedure?

To file a formal grievance, you, or your authorized representative must submit the grievance to us in writing at this address: Ombudsperson/Customer Service, WEA Insurance Corporation, P.O. Box 7338, Madison, WI 53707-7338. Your written grievance may be submitted in any form, but should include the following information:

- The employee's name and subscriber number
- Why you are dissatisfied
- All relevant information, including dates and events in chronological order and names of any providers involved
- Copies of any documents that relate to your grievance
- What you believe to be a fair resolution of your grievance

We will acknowledge receipt of your grievance within five business days after we receive it. Within 30 days after receiving it, your grievance will be considered by our Grievance Committee. If we are unable to make a decision within the 30-day time limit, we may extend the limit an additional 30 days. We will inform you in writing of the reason for the extension and the date by which the decision may be expected.

The Grievance Committee is composed of three or more members, one of whom is authorized to take the corrective action the Committee deems appropriate. At least one Committee member will be a WEA Trust plan member who is not a company employee if one is available to serve on the Committee. We will notify you of the Grievance Committee meeting at least seven days in advance.

You, or your authorized representative, have the right to appear in person, or by telephone, to present information, ask questions, or submit written questions. You should know that if you submit additional information to the Committee that was not previously submitted to the company, the Committee's review and determination may be delayed until the newly submitted information can be reviewed and considered. Any expenses you incur in connection with the grievance are your responsibility.

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 grievance procedure for an expedited grievance?

The expedited grievance procedure is reserved for those grievances where the normal duration of the grievance resolution process could have adverse health effects for the plan participant, such as serious jeopardy to life or health, or unmanageable severe pain. If you have an expedited grievance request situation, you should report it immediately to the Ombudsperson by calling (800) 279-4000. WEA Trust's Expedited Grievance Committee will investigate your expedited grievance and call you with our decision as quickly as possible but not more than 72 hours after our receipt of your request for an expedited grievance. You will then receive a written confirmation of the decision.

You may request an expedited independent external review of a denial decision when you send us your request for an expedited grievance. Assignment of an IRO will be done by rotation among IROs maintained by WEA Trust. The IRO's medical director, or other medical professional, will review your request and decide if an immediate review is needed. If so, it will review your dispute on an expedited basis and it must notify you and us of its decision no later than 72 hours after receiving the review request. If the IRO decides that your health condition does not require its immediate review of your dispute, it will notify you that you must first complete the internal grievance process.

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.

Who conducts the independent reviews?

The independent review process provides you with an opportunity to have medical professionals who have no connection to us review your dispute. The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The IRO has the authority to determine whether the treatment should be covered by us.

Assignment of an IRO will be done by rotation among approved IROs maintained by WEA Trust. An approved IRO must demonstrate that it is unbiased and that it has procedures to ensure that its clinical peer reviewers are qualified and independent.

What types of disputes can be decided through independent review?

The dispute must involve coverage denial determinations that relate to medical necessity, health care setting, medical appropriateness, level of care, or experimental treatment. The treatment must otherwise be a covered benefit under your insurance contract.

If you or we disagree about whether or not your dispute is eligible for independent review, the IRO that has been selected will decide if it has the authority to do the review.

What types of disputes are not eligible for independent review?

No health benefit plan covers all medical expenses. 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.

How do I request an independent review?

In most cases, you will need to exhaust our internal grievance process. When you receive our final grievance decision, we will provide you with information on your right to request an independent review, if your dispute qualifies for independent review. To request an independent review, send your written request for an IER to the Grievance Chairperson, WEA Insurance Corporation, 45 Nob Hill Road, Madison, Wisconsin, 53713-7338. You must send your request for IER to us within four months of the date of the Grievance Committee's decision letter.

What if I need care now?

Generally, you must exhaust our internal grievance process before requesting an independent review. However, you do not need to complete this process if both you and we agree to proceed directly to independent review or if you need immediate medical care. If you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize your life or health, you may ask to bypass our internal grievance process. To do so, contact our Ombudsperson, who will evaluate your request and arrange for the review of the dispute by an IRO. If the IRO determines that an immediate review is needed, it will review your dispute on an expedited basis. If the IRO decides that your health condition does not require its immediate review of your dispute, it will notify you that you must first complete our internal grievance process.

Is there a cost involved?

There is no cost to you. We will pay the cost of the reviewer's fee.

How long does the independent review process take?

We must send all relevant medical records and other documentation used in making our decision to the IRO within five business days. The IRO may then request any additional information it may need from us or from you. The IRO must make its decision within 45 calendar days after receiving the review request. After it receives the information it needs, the IRO has 45 calendar days to make its decision.

If the IRO determines that this time period could jeopardize your life or health, we must send our documentation to the IRO within one day and the IRO then has two business days to request any additional information. The IRO must make its decision within 72 hours after receiving the review request.

How does the IRO make its decision?

All of the documentation and other information provided by you and by us is reviewed by a clinical peer reviewer who must be an expert in the treatment of your medical condition and knowledgeable about the recommended health care service. In reviewing a case involving medical necessity, the IRO and its reviewer are required to consider all of the documentation, including your medical records, your attending provider's recommendation, the terms of coverage of your health plan, the rationale for our prior decision, and any medical or scientific evidence.

Does my health plan have to abide by the decision?

Yes, the decision of the IRO is binding on both us and on you.

What if I have more questions?

Our Ombudsperson 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.

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 44,000 providers serving the state of Wisconsin:

- 14,450 physicians
- 28,738 practitioners
- 144 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 health care 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
- 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

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 providers 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 or in rare instances of strongly countervailing public interest or 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, sexual orientation, age, veteran, or 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. Determinations as to which applicants require additional individual review by the WEA Trust Credentialing Committee are made according to predetermined criteria related to professional conduct and competence as outlined in WEA Trust's credential program standards. Credentialing Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

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 health care costs by negotiating preferential prices for health care 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 the 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.

Never Events and Preventable Adverse Events

In the event of a “never event” or preventable adverse event, the practitioner or hospital shall not bill, seek to neither collect from nor accept any payment from WEA Trust or the patient. “Never Events” and preventable adverse events include but are not limited to the following:

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure performed on patient

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 personal Harmony nurse—one nurse, one person partnered together in care. The Harmony nurse 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 health care 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 health care 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 health care 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 health care 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, multiple sclerosis, rheumatoid arthritis, stroke
- Multiple emergency room visits, multiple inpatient stays, high costs care on specialty medications
- Traumatic accidents or injury
- Transplants

We have a rheumatoid arthritis outreach program that engages members and uses motivational interviewing techniques to help them get past barriers to adherence to medications and other prescribed therapies. Non-adherence to arthritis medications leads to progression of disease with increasing disability, lost work time, and higher medical costs. The program is called R.A.R.E. the Rheumatoid Arthritis Review and Education program. Adherence to lower cost medications can slow disease progression and lessen the drug and medical spend, which is shown to be associated with high cost variations and needed work absence for infused treatments on an outpatient basis.

Strategies Harmony Nurses take:

- Review medications for conflicts, concerns, improvement opportunities in consultation with a consultant pharmacist.
- Help solve current problems/concerns.
- Coordinate efforts of/communication between multiple providers.
- 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).

Clinical Quality Improvement

Quality Program

The purpose of the clinical quality improvement program at WEA Trust is to identify and improve health care, 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 health care 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

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.

In addition, 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.

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.

Newly Added Services that Require Preauthorization

Effective January 4, 2016:

- Electroconvulsive Therapy
- Transmagnetic Stimulation

Effective March 15, 2016:

- Transcatheter Pulmonary Valve Implantation

Effective June 1, 2016:

- Continuous Glucose Monitors and Supplies
- Dialysis (home and outpatient)
- Elective Inpatient Hospital Admission
- Hyperbaric Oxygen Therapy
- Insulin Pumps and Supplies

Effective September 1, 2016:

- Autologous Chondrocyte Implantation
- Cochlear Implants
- Gastric neurostimulators
- Impression and Customer Preparation; Speech Aid Prosthesis
- Osteochondral Autograft Knee, Open
- Tens Units
- Whole Body Imaging

Effective January 1, 2017:

- LINX

Services Requiring Preauthorization

- Advanced Imaging Scans (e.g. MRI, CT scans) of the neck and spine provided on an outpatient basis. Such scans provided while you are inpatient or provided as part of emergency care are not subject to preauthorization.
- Apnea Monitors and Oral Appliances for the treatment of Apnea
- Artificial Limbs
- Back Surgeries for Pain
- Certain High-Cost Durable Medical Equipment, Prosthetics, Orthotics and Oxygen-Related
- Equipment and Services
- CPAP, BiPAP and VPAP Machines
- Chest Compression System
- Custom Back Braces
- Defibrillator Vest
- Enteral Nutrition
- Genetic Testing
- Home Health Services - Including Wound Care
- Home Infusion
- Home Infusion/Ambulatory Infusion Pumps
- Inpatient Stays
- Invasive Back Procedures
- LINX
- Lower Extremity Back Braces
- MRA ScansNuclear Medicine – Cardiology (Myocardial Perfusion Imaging, Tomographic/Planar)
- Orthognathic Procedures **These are still not covered for WEA Trust members in the State Health plan
- Oxygen Concentrators
- PET Scans
- Physical, Speech, and Occupational Therapy Services (excluding evaluations)
- Power Operated Vehicles (i.e. scooters)
- Power Wheelchairs and Accessories
- Psychological and Neuropsychological Testing [Use this form when requesting authorization]
- Reconstructive or Plastic Surgery such as, but not limited to:
    - Abdominoplasty
    - Blepharoplasty and Ptosis Repair
    - Brachioplasty
    - Breast Augmentation, Lift, or other Breast Reconstructive Surgery
    - Panniculectomy
    - Thighplasty
    - Treatment of Varicose Veins
- Skilled Nursing Facility Care
- Skilled Rehabilitation Services
- Sleep Studies
- Specialty Drugs and High-Cost Drugs with unique monitoring or delivery needs
- Specialty Beds and Accessories
- Stimulators – Bone, Brain, Spinal Cord
- Surgical Sleep Disorder Treatment Total Joint Replacement
- Transplant Evaluations, Services and Procedures
- Treatment of Temporomandibular Disorders (TMD)
- Ventilators and Supplies

All Advanced Imaging Scans Require Preauthorization for State Health Plan Members.

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 Customer 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

Rehabilitation Medicine

Physical, speech, and occupational therapy services, excluding initial evaluation, requires preauthorization through Magellan Healthcare.

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.

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.

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

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

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

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.

MedImpact can be reached at (888) 807-8106.

Home Delivery

Our home delivery service is with NoviXus. 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. NoviXus can be reached at (877) 668-4987.

Specialty Pharmacy

Our specialty pharmacy is Diplomat Specialty Pharmacy. 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. Diplomat Specialty Pharmacy is the country's largest independent specialty pharmacy.

Diplomat Specialty Pharmacy can be reached at (877) 319-6337.

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
- Tier 3 - All Other Drugs (highest copayment)

We have a select list of value drugs which are available at $0 cost or low 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.

Note: This list may change. If you have further questions regarding value drugs you should contact our Customer Service Department at (800) 279-4090.

Prescription Drug Preauthorization

WEA Trust requires preauthorization for certain prescription drugs. Depending on the drug, either MedImpact, Coram Specialty Infusion Services, or WEA Trust will handle preauthorization. The sections below detail which drugs are handled by which company. Our list of prescription drugs that require preauthorization can be found on our website at www.weatrust.com/provider/preauthorization.

Note: This list may change. If you have further questions on what prescription drugs require preauthorization you should contact our Customer Service Department at (800) 279-4090.

MedImpact (888) 807-8106	Coram (888) 439-3661	WEA TRUST (800) 279-4000
Adapalene (over age 25)	Aldurazyme (laronidase-J1931)	Antihemophilic factors (Factors VIII/IX)
Androgel	Aralast (J0256)	Botulinum toxin (Botox)
Aripiprazole	Bivigam (J1556)	Epoetin (Epogen/Procrit)
Copaxone	Carimune (J1566)	Herceptin (trastuzumab-J9355)
Crestor	Ceredase (alglucerase-J0205)	Interferon and Peginterferon for Hepatitis B
Dextroamphetamine-ampetamine (quantity limit)	Cerezyme (imiglucerase-J1786)	Kadcyla (adotrastuzumab-J9354)
Dextroamphetamine-amphetamine ER (over age 18)	Elaprase (idursulfase-J1743)	Lupron
Elidel	Fabrazyme (agalsidase-J0180)	Orencia
Enbrel	Flebogamma (J1572)	Prolia
Enoxaparin Sodium	Gamastan S/D (J1460)	Reclast/Zometa (zoledronic acid)
Fentanyl	Gammagard Liquid (J1569)	Remicade
Gleevec	Gammagard S/D (J1566)	Rituxan
Harvoni	Gammaked (J1561)	Simponi Aria

MedImpact (888) 807-8106	Coram (888) 439-3661	WEA TRUST (800) 279-4000
Humira	Gammaplex (J1557)	Soliris
Imiquimod	Gamunex (J1561)	Stelara
Jublia	Gamunex C (J1561)	Tysabri
Latuda	Glassia (J0256)	Vivitrol (J2315)
Methlyphenidate ER (over age 18)	Hizentra (J1559)	Xolair
Modafinil	Lumizyme (alglucosidase- J0221)	Yervoy (ipilimumab-J9228)
Neulasta	Myozyme (aglucosiderase-J0220)	
Nexium	Naglazyme (galsulfase-J1458)	
Nuvaring	Octagam (J1568)	
Nuvigil	Privigen (J1459)	
Pristiq ER	Vpriv (valaglucerase alfa-J3385)	
Sovaldi	Zemaira (alpha 1 proteinase-J0256)	
Subuxone		
Tecfidera		
Tretinoin (over age 25)		
Vancomycin		
Vesicare		
Vyvanse		
Xyrem		
Zolpidem tartrate ER		

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 electronically. If you submit electronically, you have agreed to do so in an electronic format that meets HIPAA transaction and code set requirements as of the HIPAA compliance deadline established. 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

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

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
- 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.

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. 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.

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, but will need to be printed and faxed to (608) 276-9119 or mailed to:

WEA Trust Insurance
Attn: Claims Resubmission Request
P.O. Box 8220
Madison, WI 53708-8220

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 health care services performed. You may not charge, collect a deposit from, bill, or in any way seek compensation from a Participant for health care 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.

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.

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:

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.

Modifier	Description	WEA Reimbursement Policy
Modifier 25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care 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.

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 76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	Informational modifier no additional reimbursement.
Modifier 78	Return to operating room for related procedure during post-op period	Reimburse at 100% 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.
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	Description	WEA Reimbursement Policy
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.

Credentialing Policies and Procedures

Credentialing is an important process WEA Trust uses to ensure that we offer quality care to our members. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide patient care services. Providers must meet minimum standards for licensure, education, malpractice 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. WEA Trust makes all credentialing and recredentialing decisions based solely on the verified information provided on the provider's applications, and does not discriminate against an applicant or make credentialing decisions based on an applicant'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. On receiving the completed form, WEA Trust's credentialing staff will determine whether credentialing is required prior to enrollment 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 Agency (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 the 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.

d. Not be subject to current sanction, discipline, debarment or exclusion from participation in Medicare, Medicaid, Tricare, Federal Employees Health Benefits, or other government health care program.

e. Submit a complete and accurate application and timely response to the 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 (see policy CR34).

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 health care 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.

Recredentialing

WEA Trust requires participating providers to comply with periodic recredentialing to ensure that they continue to meet established standards. The recredentialing process incorporates re-verification of information previously submitted to WEA Trust and the identification of any changes in the provider's licensure, professional liability insurance coverage, health status and/or ability to perform.

Providers who are due for recredentialing will receive a pre-populated application from WEA Trust's Credentialing staff in advance of the date due. Providers will be required to timely complete and return the application to enable completion of the verification process within required time frames and prevent termination of network participation.

Ongoing Monitoring

WEA Trust performs ongoing review and monitoring to ensure providers continued compliance with established credentialing standards. Providers must notify WEA Trust within ten calendar days of:

1. Any finding of any licensing or regulatory authority that restricts, suspends, or revokes a provider's license, certification, accreditation, or Medicare or Medical Assistance participation status
2. Any voluntary surrender of a license while under scrutiny or to avoid scrutiny
3. Any censures, reprimands, terminations, suspensions, or probations of clinical privileges or involuntary termination of health care service contracts
4. Any adverse final judgment of a suit, action, or proceeding brought against the provider for medical malpractice
5. Any health care related final civil judgments or injunctions, monetary penalties or injunctions
6. Any felony and/or misdemeanor criminal convictions

Credentialing Confidentiality

Information obtained during the credentialing process is confidential. Access to credentialing data in WEA Trust's provider database is limited to staff who work directly with the credentialing process. Credentialing information will not be released to outside parties without permission of the provider involved, or as permitted by law, including the Health Care Quality Improvement Act of 1986.

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 health care 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 health care 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 7338
Madison, WI 53708-8220

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

- Provider's name
- Contact information for provider and/or person submitting the appeal
- 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 60 days and the healthcare professional will receive notification in writing of the dispute resolution within 75 days of receipt of the original dispute. If an appeal determination overturns the initial decision, claims will be reprocessed within 30 days.

Provider Network Management

This reference guide was produced by the Provider Network Management (PNM) Department in order to assist in the day-to-day operation of the various WEA Trust Network Providers.

For additional assistance, a Lead Provider Service Representative is available and can clarify WEA Trust's policies and procedures as well as assist in problem resolution.

The Lead Provider Service Representative 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

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 Network Manager..... (608) 661-6666

Richard Darga – Provider Contract Manager..... (608) 661-6689

Lisa Richter – Provider Contract Manager..... (608) 661-6603

Chris Auger – Provider Contract Manager..... (608) 661-6754

Bridget King – Lead Provider Services Representative ..... (608) 395-6230

Nora Moses – Supervisor of Credentialing ..... (608) 395-6311

Provider Service Phone Number ..... (800) 279-4090