WINFertility Managed Provider Manual

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Summary of Clinical Protocols for HMOI & Cigna

Updated March 2022

I. Protocol for Work Up Prior to Requesting Authorization of Services for Induction of Ovulation and Assisted Reproductive Technology

Evaluation of Fallopian Tubes (or previous study from the referring MD)

Tubal occlusive disease must be specifically excluded for all patients by using one or more of the following tests. A tubal study can be waived in the presence of multi-factorial indication for IVF.

- Hysterosalpingography (HSG) – primary
- Air-contrast sonohysterography (aka Femvue)
- Laparoscopy and "Chromopertubation" when indications other than infertility
- Fluoroscopic and/Hysteroscopic selective tubal cannulation in cases of proximal tubal occlusion on HSG

Evaluation of Uterine Cavity (or previous study from the referring MD)

In cases of abnormal endometrial cavity on HSG, or for patient's pre-IVF:

- Hysterosonography (HSN) – primary
- Air-contrast sonohysterography (aka Femvue)
- Hysteroscopy if HSN is abnormal or not diagnostic
- Uterine cavity studies should be completed within one year of a planned embryo transfer

Criteria for the Evaluation of Ovarian Reserve

The following patients must be screened to provide prognostic information:

- Women at age 35 and older
- Any women with unexplained infertility
- Any women w/history of previous ovarian surgery, any woman with a single ovary, or prior chemotherapy or pelvic irradiation
- Any patient with a family history of early menopause
- Any patient with documented poor response to exogenous gonadotropin stimulation

Ovarian Reserve must be screened during infertility treatment cycles

- Annual assessment of ovarian reserve is required for all women over age 35 who are using autologous eggs. This will not apply as a requirement for a frozen embryo transfer. Annual assessment is not required if the initial testing results in an undetectable AMH (<0.1mg/ml).

Diagnostic Studies for the Evaluation of Ovarian Reserve

The following diagnostic studies to be used to evaluate ovarian reserve are:

- Cycle day 2/3 FSH/E2 and/or AMH (Anti-Mullerian Hormone)
- Transvaginal ultrasound for antral follicle count (AFC)

Evaluation of Semen Specimens

- A comprehensive (including volume, concentration, motility, and morphology) semen analysis must be completed prior to any infertility treatment cycles (e.g. IUI/IVF). If normal the submitted semen analysis should be within 2 years of cycle start. If abnormal the semen analysis should be updated within 1 year of cycle start. Morphology not required with repeat semen analysis.
- Two semen analyses are recommended prior to categorization of the male as subfertile or infertile

    - A minimum of 5 M/ml motile sperm is recommended in a specimen for IUI- specimens with lower counts are associated with significantly lower success rates with IUI and may be indications for IVF w/ ICSI.
    - Evaluation of semen parameters are based on WHO criteria and/or Strict Kruger Morphology
    - WHO criteria for normal values
    - Volume > 1.5ml
    - Concentration/Count 15M/ml or greater
    - Motility 40% or more with forward progression in > 32%
    - Morphology of greater than or equal to 4%
    - Strict Kruger Morphology of > 14% is optimal, 4 to 14% is suboptimal but still offers fair to good prognosis

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II. Protocol for the allowable number of IUI cycles

Natural Cycles

- 4 cycles for women < 35 and 3 or less cycles for older women (there is no requirement for natural cycle IUI prior to use of clomiphene citrate/letrozole with IUI). Women under 35 without infertility undergoing donor insemination (single or same-sex female couples) should undergo 6 cycles of donor IUI (either natural cycle or with an ovulation induction agent) prior to moving to more aggressive treatment. For older women it is reasonable to undergo 3 or more cycles and that tubal patency and ovarian reserve are assessed after 3 failed cycles. If other infertility factors are present, such as diminished ovarian reserve, the requirement for 6 donor insemination cycles may be waived on an individual basis and more aggressive treatment should be considered on an individual basis.

Clomid/Letrozole Cycles

- For unexplained infertility, a maximum of 4 IUI cycles
- For women with a diagnosis of anovulation and normal semen parameters, IUI is not a required step. Timed intercourse is an acceptable alternative.
  For anovulation, a maximum of 6 ovulatory cycles with IUI. If not responsive to lower doses, 7.5mg Letrozole required before gonadotropins or IVF for anovulatory PCOS patients.

- Patients under 38 with unexplained infertility
  - Should undergo at least 3 cycles of clomiphene citrate or letrozole with IUI before attempting more advanced treatments such as IVF or IUI with gonadotropins*. A maximum of 4 cycles may be completed before recommending movement to more advanced treatment. Patients under 38 with evidence of diminished ovarian reserve may move directly to more advanced treatment (preferably IVF). Gonadotropin/IUI therapy is not a required step.
- Patients 38 and over with unexplained infertility
  - May move directly to IVF or IUI with gonadotropins and bypass the clomiphene/letrozole IUI treatments given their very low efficacy. A maximum of 4 clomiphene IUI cycles may be completed before recommending movement to more advanced treatment. Gonadotropin/IUI therapy is not a required step.
- Patients 43 and over
  - Should be discouraged from attempting clomiphene/letrozole IUI and should move directly to IUI with gonadotropins or IVF, or oocyte donation, when appropriate, given the absence of efficacy of clomiphene/letrozole IUI in this age group. Gonadotropin/IUI therapy is not a required step.

Gonadotropin Cycles

For unexplained infertility, 4 cycles of gonadotropin IUI are recommended as the maximum number of cycles. There is an absolute maximum of 4 gonadotropin IUI cycles. WIN recommends directly moving to IVF after failing to conceive with IUI with clomiphene/letrozole in order to avoid complications of multiple pregnancy. However, IUI with gonadotropins is an acceptable alternative.

- For anovulation, a maximum of 6 ovulatory cycles and then IVF should be offered. Patients at high risk for multiple pregnancy may proceed directly to IVF without prior use of gonadotropins for ovulation induction.

NOTE: Higher success rates have been demonstrated with IUI compared with intracervical or intravaginal insemination. There is no evidence that having 2 IUIs on successive days is more successful than a single well timed IUI. IUI is NOT indicated in patients with severe tubal disease or in cases with significant male factor infertility.

III. Indications for IVF (ASRM)

In vitro fertilization (IVF) is a commonly performed treatment for infertility. The indications for IVF include:

- Male Factor (see Guideline 13: Indications for ICSI)
- Tubal occlusion (proximal or distal), pelvic adhesions
- Endometriosis
  - Stage I or II in women over 38 or with significant diminished ovarian reserve
  - Stage I or II in women under 38 who have failed to conceive with at least 3 clomiphene/letrozole IUI cycles
  - Stage III or IV, regardless of age
- Idiopathic infertility
  - Women 38 and over may consider immediate IVF as there is a higher pregnancy rate and shorter time to pregnancy compared to ovarian stimulation (medications or gonadotropins) with IUI.
  - Under age 38 with significantly diminished ovarian reserve
  - Under age 38 who have failed to conceive with at least 3 clomiphene/letrozole IUI cycles
- Diminished ovarian reserve, but responsive to gonadotropins
- Unexplained Recurrent Pregnancy Loss
- Recurrent Pregnancy Loss Caused by a Balanced Translocation

Backwards movement in treatment from IVF to IUI

- Allowable if clinically appropriate; i.e. at least one open fallopian tube with normal ovarian reserve and at least 5 million motile sperm
- Must be within allowable maximum number of IUI cycles as referenced above

IV. Protocol for ICSI Guidelines

- Oligozoospermia (< 15 M/ml)
- Asthenozoospermia (<40%)
- Low total motile sperm count (<15 million)
- Teratozoospermia (strict morphology < 4%)
- History of poor or failed fertilization after conventional IVF (equal to or >50% of oocytes unfertilized in a prior cycle)
- Positive anti-sperm antibodies
- Cryopreserved sperm from cancer patients in remission
- Spinal cord injury patients – electroejaculated sperm
- Surgically retrieved sperm (epididymal or testicular)

Summary of Clinical Protocols for HMOI & Cigna

An additional indication for ICSI decided upon by the WIN Medical Advisors is a “post-wash” total motile sperm count under 10 million

Other indications for ICSI which are not part of standard infertility care include:

- PGD for single gene defect (PGT-M)
- In vitro matured oocytes (experimental)
- Cryopreserved oocytes

Quick Reference Guide for Clinical Services for Infertility/IVF Services Providers and Staff for HMOI & Cigna

Updated December 2020

WINFertility

Phone: (877) 444-7271

Fax: (877) 369-4560

Using the WINFertility Forms

Please refer to pages 53 - 57 of this Manual Addendum for complete instructions.

Referral from Primary OB/GYN or PCP for New Patient

The Primary OB/GYN or PCP makes the initial diagnosis of infertility and issues a Global Referral to an infertility specialist.

Complete and fax the "Request for Authorization Form" along with the referral from the primary OB/GYN or PCP to WIN and the results of all diagnostic tests performed in the primary care office, before the patient's first appointment. No cover sheet is required.

Medical History Form

Complete the patient's workup. Include the details of past treatment cycles and recent required diagnostic test results (e.g. semen analysis, evaluation of ovarian reserve) on the "Medical History Form".

Fax to WIN. No cover sheet is required.

Request for Prior Authorization

All services require prior authorization.

Complete and fax the "Request for Prior Authorization Form" to WIN. No cover sheet is required.

WIN will review the request and determine authorization for services.

Reporting Outcome Data

Outcomes on all authorized services for patients must be reported to WINFertility.The appropriate Outcome Form for each authorized treatment must be completed before a claim is submitted.

Complete the appropriate Outcome Form for each authorized service with all requested outcome data. Incomplete forms will be returned for completion.

Fax to WIN. No cover sheet is required.

Claims

All claims must include the Authorization Number issued by WINFertility.

All medical claims should be submitted via EDI or printed on original HCFA 1500 form and mailed to:
WINFertility, Inc. - Claims Department
Greenwich American Center
1 American Lane, Terrace Level

Summary of Clinical Protocols for HMOI & Cigna

Greenwich, CT 06831

Outcomes of the services you are billing for must be submitted to WIN prior to submitting the claims, to avoid any delay in processing.

Quick Reference Guide for Pharmacy Services

Updated December 2020

for Infertility/IVF Services for HMOI & Cigna

Use the WINFertility Prescription Form or Donor Prescription Form specific to HMOI or Cigna

Initial Prescriptions

Providers and Staff	Members
Phone: (877) 444-7271 Fax: (877) 369-4560	Phone: (877) 444-7299

Using the WINFertility Infertility Prescription Form

Prescribing Pharmaceuticals

Complete all sections of the Infertility Prescription Form for all HMO Illinois members. Please be sure to include complete dosing instructions.

Choose from the WINFertility Brand Name Formulary Drugs:

- Follistim
- Menopur
- Ganirelix
- Endometrin

Complete the space provided for "Pharmacy" with your choice of pharmacy from the following:

- Village Pharmacy
- Freedom Drug
- Walgreens/Alliance
- Braun
- MDRX

Ordering Initial Pharmaceuticals

Fax the completed Infertility Prescription Form to WIN- WITH THE EXCEPTION OF FREEDOM DRUG, DO NOT FAX DIRECTLY TO THE PHARMACY. This will cause a delay in the dispensing of medication.

Fax the form along with completed clinical forms at least 5 days prior to your patient's anticipated start date, to avoid any unnecessary delays or inconvenience to your patient.

Pharmaceuticals for new cycles will NOT be approved until outcomes of the previous cycles have been received and a new requested service is approved.

Dispensing Limits

WINFertility preferred formulary drugs should be used for all patients.

The following represents the maximum dispensing limits:

- Follistim- 4500 iu
- Ganirelix- 5 vials
- Menopur- 4500 iu

In the rare instances where WIN non-preferred formulary drugs are requested, a Medical Necessity Form must be completed and approved by WIN Medical Management. The following represents the maximum dispensing limits for the WIN non-preferred formulary:

- Gonal F- 4500 iu

Gonadotropins are manufactured in various package sizes. The specific package size combination that the pharmacy dispenses will be calculated to minimize quantity of patient injections and drug waste. Samples of these dosage calculations are included in the Provider Manual.

Ordering Refills

Have your patient call WIN's toll-free number to order refills.

If the patient is starting a new cycle, outcomes of the previous cycle and the request for additional services must be received and approved before the medication refill can be approved.

Global Referral from primary OB/GYN or PCP

- A copy of the Global referral from the primary OB/GYN or PCP must be sent to WINFertility with two patient identifiers and the primary diagnosis of infertility. Please note referrals written on a prescription are not acceptable. The primary OB/GYN or PCP makes the initial diagnosis of infertility when the mandated requirements for a diagnosis of infertility have been met.
- The Global referral from the OB/GYN or PCP to the Infertility Specialist must be indicated/documented as a “Global” referral. The referral is for the total treatment of the infertility patient, which also includes surgery.
- Global referrals are kept on file at WINFertility and need only to be faxed one time unless an updated Global referral is required. Without a Global referral, requests for authorization cannot be acted upon and will be returned to your office pending the receipt of the Global referral.
- A new Global referral is required after a live birth. The patient will need a new Global referral from their OB/GYN or PCP to see the participating infertility provider.
- A new Global referral is required if the member changes medical groups (or IPA – independent practice association). The patient will need a new Global referral from their OB/GYN or PCP to see the participating infertility provider.

Member Eligibility

- The patient’s insurance eligibility is confirmed by WINFertility before authorizations are issued. Please fax in a copy of the Member ID Card (front and back) with initial service request.
- The patient’s name must be spelled correctly and clearly as indicated on the Member ID Card.
- The Member ID # and Group # must be written correctly and clearly in the space provided. This can also be found on the Member ID card. The member ID # may not be the patient’s social security number.
- If either a Member ID # or Group # changes from the previous submission to WINFertility, please inform WINFertility in writing. Please fax in a copy of the Member ID Card (front and back) at time of change.

WINFertility Clinical Protocols

- Clinical protocols delineate the testing criteria to be used when working up the infertility patients. These studies must be completed prior to approval of induction of ovulation and assisted reproductive technology. Following the clinical protocols will reduce WINFertility’s requests for additional information from the offices and make the process of authorization efficient for all.

HMOI Instructions for Providers and Staff
Infertility Care Management Program Updated December 2020

Request for Prior Authorization Form- DXPKGB

(includes Initial consultation and/or diagnostic workup testing)

- Complete the Request for Authorization form via fax form or online portal. Complete the form in its entirety and submit to WINFertility with the Global referral.
- All authorizations will be reviewed for approval or denial based on benefit eligibility and medical appropriateness.
- After completion of the Initial consult and diagnostic workup, the Diagnostic Outcome Form must be completed and submitted to WINFertility via fax or online portal.

Completing the Diagnostic Outcome Form

- **Office information**: The physician license # is the unique identifier of the physicians that practice in large groups. Since the physicians may practice in several offices, it is important to know where to return the authorizations and other office communications. This section will be pre-filled with the appropriate authorization number and fax/phone numbers for the requested office, for the diagnostic workup and faxed to your office when your request for diagnostic workup is approved. Please be sure the information is correct. If the information is not correct please be sure to notify WIN of the changes needed.
- **Patient information:** The Member ID # and date of birth are the unique identifiers of the patient. The patient information section will be pre-filled with the information from the payor's eligibility files. Please be sure the information is correct.
- **Service Results:** There are different types of diagnostic workup packages that are authorized through WINFertility (e.g. diagnostic package, recurrent pregnancy loss package, semen analysis). Please check the appropriate package that was performed, and submit the supporting documentation once the work-up is completed. (Male / Female voluntary sterilization status and pap/cultures information is required to complete an outcome)
- **Sections 1-4:** These sections are specific to the type of diagnostic workup performed. Please complete the appropriate section for the authorized/performed service in its entirety.
- **Signature of Treating Physician:** The treating physician (or his designee) is required to sign and date all outcome forms if faxing and submitting a hard copy form (the online portal does not require a signature)

Completing the Medical History Form

- **The Medical History Form** is to be completed and submitted to WINFertility once the member's diagnostic work up and testing is completed. The submission of the Medical History Form is required with the Diagnostic outcome form when testing was completed under the Diagnostic Workup Package (DXPKGB), unless a consult only outcome was indicated. The submission of Medical History Form is also required before review of any request for Prior authorization of treatment.
- Authorization for requested treatment cannot be approved without the completion of the medical history form.
- The clinical protocols set the minimum requirements for patient testing prior to requesting authorization for treatment. A complete Medical History Form allows the Care Manager to determine medical necessity prior to authorizing services and reduces the need to return the request to the physician's office for the additional information.

- **Office information:** The physician license # is the unique identifier of the physicians that practice in large groups. Since the physicians may practice in several offices, it is important to know where to return the authorizations and other office communications. This section will be pre-filled with the appropriate authorization number and fax/phone numbers for the requested office, for the diagnostic workup and faxed to your office when your request for diagnostic workup is approved. Please be sure the information is correct.
- **Patient information:** The Member ID # and date of birth are the unique identifiers of the patient. The patient information section will be pre-filled with the information from the payer's eligibility files. Please be sure the information is correct.
- **Section 1: Contact Information:** The patient's most current information as supplied to your office should be completed in this section. The address and phone numbers are important for contacting the members for medication delivery.
- **Section 2: Female Infertility and Conception History:** to be completed with the available information. The Duration of Infertility field is required.
- **Section 3: Female Surgical History:** Previous voluntary sterilization must be reported as well as any reversal information. Tubal patency must be demonstrated post reversal and the couple must have unprotected intercourse for 6 month to a year, depending on the age and history of the patient, before the patient is eligible for infertility benefit.
- **Section 4: Male Surgical History:** Previous voluntary sterilization must be reported as well as any reversal information. A normal semen analysis must be demonstrated post reversal and the couple must have unprotected intercourse for 6 month to a year, depending on the age and history of the patient, before the patient is eligible for infertility benefit. Each Health plan has specific criteria that is set to determine a reversal is successful.
- **Section 5: Semen Analysis:** Prewashed semen analysis results performed within the past year should be entered here. Comprehensive (this includes morphology) semen analysis is needed prior to any fertility treatment.
- **Section 6: Preconceptual Screening:** To be completed with the available information from the workup and any prior medical history from the referring physician (Pap smear, Cervical cultures are required)
- **Section 7: Tubal/Uterine Cavity Evaluation:** Criteria for the evaluation of the tubes and uterine cavity are found in Clinical Protocols. Demonstration of tubal patency must be done prior to requesting ovulation induction.
- **Previous Cycle History:** Specific details about the patient's past treatment cycles are required and must include the number of prior ovulation induction cycles, prior IVF and prior donor cycles as well as the outcome of each cycle. The Illinois State Mandate limits the infertility benefit. These fields provide WINFertility with the information needed to keep track of ovulation induction cycles, all retrievals and the outcome of the cycles. Knowing the outcome of these cycles is required so that WINFertility has all the information needed to determine the member's eligibility for infertility benefits.

Request for Prior Authorization Form - Treatment

- When the Physician requests treatment for the patient, check the appropriate box within the treatment categories of the acceptable global codes. All services require Prior Authorization in

advance by a WINFertility Medical Director/Care Manager. Authorization is based on medical necessity and is subject to contract limitations.

- **Office information:** The physician license # is the unique identifier of the physicians that practice in large groups. Since the physicians may practice in several offices, it is important to know where to return the authorizations and other office communications. This section will be pre-filled with the appropriate authorization number and fax/phone numbers for the requested office, for the diagnostic workup and faxed to your office when your request for diagnostic workup is approved. Please be sure the information is correct. If the information is not correct please be sure to notify WIN of the changes needed.

HMOI Instructions for Providers and Staff
Infertility Care Management Program Updated December 2020

- **Patient information:** The Member ID # and date of birth are the unique identifiers of the patient. The patient information section will be pre-filled with the information from the payer's eligibility files. Please be sure the information is correct. If the information is not correct please be sure to notify WIN of the changes needed.
- **Signature of Treating Physician:** The treating physician (or his designee) is required to sign and date all prior authorization forms if faxing and submitting a hard copy form (the online portal does not require a signature)
- After a review of the Medical History Form and any prior Outcome Forms of the previous cycles, the Care Managers determine the medical necessity of the request. Upon approval of a service, the authorization number will be generated and notification will be sent to your office along with the appropriate Outcome Form for that service.
- The WINFertility authorization number will have a start date & expiration date. These dates will be noted on the form. Different bundled packages have different date ranges. For example, an IVF cycle approval is typically a three-month date range. A diagnostic package is also a threemonth date range. This allows you to have time to start and finish testing and/or treatment.
- Once an authorization has expired, if the service has not been performed, the outcome form for that authorization must be completed with the Service Not Rendered box checked. A new Request for Prior Authorization form may then be submitted to WINFertility for an authorization with updated date range.

Case Closure - Fax Cover Letter

- In some instances, requests for services will be marked “case closed” for additional information. A fax cover letter will be forwarded back to your office with an explanation as to what information is missing and required to complete the determination for an authorization. Case closure letters will be sent to both the member and the practitioner explaining that not enough clinical information was received in order for the Medical Director to make a determination
- The provider should initiate a new request for service with the required information once it is available. Upon approval of a service, the authorization number will be generated and notification will be sent to your office along with the appropriate Outcome Form for that service.

Completing Treatment Outcome Forms

- When requesting new treatment, the outcome of the previously authorized services must be reported to WINFertility before additional services will be approved.
- Treatment outcomes on all authorized services must be reported to WINFertility. This includes patients who do not return to your office for additional treatment or for those who achieve a pregnancy.
- **Office information:** The physician license # is the unique identifier of the physicians that practice in large groups. Since the physicians may practice in several offices, it is important to know where to return the authorizations and other office communications. This section will be pre-filled with the appropriate fax/phone numbers for the requesting office and faxed to your

office when the outcome of your previous service has been received. Please be sure the information is correct.

- **Patient information:** The patient ID # and date of birth are the unique identifiers of the patient. The patient information section will be pre-filled with the information from the payer's eligibility files. Please be sure the information is correct.
- **Service Results:** This section contains the options for Services Not Rendered, Completed Cycles and Cancelled Cycles. Please check the appropriate box for the outcome of the authorized service and follow the instructions for the sections to be completed.Page 5011 CONFIDENTIAL

Infertility Prescription Forms

- **All Infertility Prescription Forms must be faxed directly to WINFertility** to (877) 369-4560 for HMOI members. Do not fax the prescription to the pharmacy, or send the patient directly to the pharmacy. Infertility medications require prior authorization by WINFertility. The Tax ID and DEA# must be included on the form.

Infertility Prescription Form: This form is to be used for all cycles except donor egg.

- **All prescriptions must be submitted on this form.** Complete all patient information; it is especially important the telephone contact numbers are current for all patients. Patients will be contacted by WINFertility within 24 hours of receipt and authorization by WINFertility for processing. A Pharmacy should also be selected for the dispensing of the medication. The innetwork pharmacies are listed on your quick reference guide and are subject to change. These are the only pharmacies you may use.

Infertility Donor Cycle Prescription Form:

- **This form is to be used only for all donor egg cycles**. The Prescription – Donor section represents the WINFertility preferred formulary. Please complete this section for all donor medications. The Prescription - Recipient section represents other commonly prescribed pharmaceuticals. Please complete this section for all recipient's medications. If you would like the donor medication shipped to your office please indicate so on this form.
- **WINFertility Preferred Formulary:** There are specific drugs that are on the WINFertility Preferred Formulary, these drugs are only used for infertility treatment and are a sub-formulary of the Blue Cross Blue Shield of Illinois formulary. In the rare instances that medical necessity requires use of a WINFertility non-preferred drug a Medical Necessity Form will be faxed to your office for completion.
- **Dispensing Gonadotropins:** Gonadotropins are manufactured in various package sizes. The specific package size combination dispensed by the pharmacy will be calculated to minimize quantity of patient injections and drug waste.
- **Commonly Prescribed Pharmaceuticals:** These drugs are commonly prescribed in a treatment cycle for infertility but can be used for treatment of other diagnosis.

Infertility Prescription Refills

- The member will call WINFertility at 877-444-7299 for all refills

- **Do not call or go directly to the pharmacy for refills. All infertility prescription refills must be faxed directly to WINFertility at 877-369-4560. Medication refills require additional prior authorization by WINFertility.**

Process for female coverage (as outlined per Illinois Fertility State Mandate and BCBSIL Provider Manual-HMO Scope of Benefits Section 2020-see Infertility Chapter)

- Obtain a Global Infertility Referral (the referring provider should diagnose the member with infertility as required by the mandate). Same sex couples and single females must still meet the definition of infertility as outlined in the Illinois mandate.
- At least one of the mandated requirements must be met for the member to have access to the infertility benefit:
- Unable to conceive after one year of unprotected sexual intercourse for females under 35; 6 months for females 35 and older
- The presence of voluntary sterilization (such as vasectomy or tubal ligation) is considered 'protection' for sexual intercourse, and thus does not meet the definition of infertility. In the event that a voluntary sterilization has been reversed successfully, infertility benefits will be available if the member's current clinical situation meets the definition of infertility.
- Is unable to sustain a successful pregnancy;
- Has been diagnosed by a physician as having a medical condition that renders conception impossible through unprotected sexual intercourse; or
- Has undergone one year of medically based and supervised methods of conception, including artificial insemination, which a physician has determined to have failed and are not likely to lead to a successful pregnancy. (e.g. Have proof of 1 year (or the required minimum) of IUI's with donor sperm (from a donor bank).

Process for male coverage

- If the male is covered under the female
- All medically necessary male services will be set up under the female Global Infertility Referral if both the female and male have separate Blue Cross Blue Shield of Illinois HMO
- All medically necessary male services will be set up under whomever the Global Infertility Referral was given to
- If the male only has Blue Cross Blue Shield of Illinois HMO he must receive a Global Infertility

Referral and must meet the requirements of the mandate

- Only male services will be authorized – DXPKGB , Surgery, or Medical Treatment
- If the female only has Blue Cross Blue Shield of Illinois (and male not listed on policy) no male services will be covered
- The results of specific tests are still required for the Medical History (i.e. SA)
- The infertility provider can bill the male insurance if he has other coverage, or can treat the male as a self- pay patient.

Employer Groups with Limited Infertility Benefits

The mandated A.R.T. services, if in violation of a religious institution organization's moral teachings and beliefs, may be excluded from the benefit plan. Below is a list of the religious groups who are exempt from incorporating the infertility legislation into their HMO Program. This list may not be all-inclusive

HMO Group Number	Group Name	Services Covered*
H00097	Specialty Physicians of Illinois, LLC	1 only (effective 01/01/07)
H01445	Presence Fox Knoll	1 only
H01446	Presence Mcauley Manor	1 only
H01447	Presence Health Corporate	1 only
H01448	Presence Service Corp	1 only
H01449	Presence Villa Franciscan	1 only
H01450	Presence St. Anne	1 only
H01451	Presence Cor Mariae	1 only
H01452	Presence St. Joseph	1 only
H01453	Presence Senior Services	1 only
H01455	Presence Home Care	1 only
H01456	Presence Geneva Care	1 only
H01457	Presence Pineview Care	1 only
H18189	Alverno Clinical Laboratories	1, 2, 3 (IVFGI only) 4 (IVFDG only)
H00120	Archdiocese of Chicago	1 only
H00119	Archdiocese of Chicago	1 only
H55970	Catholic Cemeteries	1 only
H57208	St. Coletta's of Illinois	1,2,3(IVFGI only), 4(IVFDG only)
H59010	Presence Health Preferred	1 only
H59051	Presence St. Francis Hospital	1 only
H59060	Presence Behavioral Health	1 only
H59075	Presence Home Health	1 only
H59076	Presence Ambulatory	1 only
H59081	Presence Resurrection System Service	1 only
H59082	Presence Holy Family	1 only
H59083	Presence St. Joseph Hospital	1 only
H59084	Presence St. Mary and Elizabeth Hospital	1 only
H59085	Presence Ambulatory	1 only
H59316	Presence Our Ladyof Resurrection	1 only

H59999	Presence Senior Services Resurrection Nursing Home	1 only
H64536	St. James Hospital	1 only
H64593	Presence Health	1 only

Employer Groups with Limited Infertility Benefits

The mandated A.R.T. services, if in violation of a religious institution organization's moral teachings and beliefs, may be excluded from the benefit plan. Below is a list of the religious groups who are exempt from incorporating the infertility legislation into their HMO Program. This list may not be all-inclusive

Blue Advantage Group Number	Group Name	Services Covered*
B00843	Presence Health Network	1 only
B00097	Specialty Physicians of Illinois, LLC	1 only (effective 01/01/07)
B02647	Presence Home Care	1 only
B02649	Presence St. Joseph Hospital	1 only
B02650	Presence Geneva Care	1 only
B02651	Presence Pineview Care	1 only
B06245	St. Coletta's of Illinois	1, 2, 3(IVFGI only), 4(IVFDG only)
B00599	Archdiocese of Chicago	1 only
B00598	Archdiocese of Chicago	1 only
B59010	Presence Health Preferred	1 only
B59051	Presence St Francis Hospital	1 only
B59060	Presence Behavioral Health	1 only
B59075	Presence Home Health	1 only
B59076	Presence Ambulatory	1 only
B59081	Presence Resurrection Systems Services	1 only
B59082	Presence Holy Family	1 only
B59083	Presence St. Joseph Hospital	1 only
B59084	Presence St. Mary and Elizabeth Hospital	1 only
B59085	Presence Ambulatory	1 only
B59316	Presence Our Lady of the Resurrection	1 only
B59999	Presence Senior Services	1 only
B64528	Wheaton Franciscan Service	1,2,3,4, 5 (standard)
B64536	St. James Hospital	1 only
B64593	Presence Resurrection Medical Center	1 only
B64594	Presence Fox Knoll	1 only
B64596	Presence Health Corporate	1 only
B64597	Presence Service Corp	1 only
B64598	Presence Villa Franciscan	1 only

B64599	Presence St. Anne	1 only
B64601	Presence Cor Mariae	1 only
B64602	Presence St. Joseph	1 only
B64603	Presence Senior Services	1 only

LEGEND CODE:	
1	Medical Evaluation and Treatment
2	Intrauterine Insemination
3	In Vitro Fertilization
3 IVFGI ONLY	Only covers GIFT only. No other IVF covered.
4	In Vitro Fertilization with Donor OOCYTES
4 IVFDG ONLY	Only covers DONOR GIFT only. No other IVF covered.
5	Frozen Embryo Thaw (FET) cycle

Catholic Affiliated and Non-Standard Groups- Customer Assistance Unit (CAU)

What if the MG/IPA is affiliated with a hospital that does not provide certain services because they are a Catholic institution, or they have a Non-Standard Agreement, and the IPA will not issue a referral for Members for infertility, sterilization or abortion services?

				Issue Referral?				
	CE#	MG#	Medical GroupName	Infertility	Sterilization	Abortion	Family Planning	Effective
	080	080	Managed Health Care Associates,LTD.	Yes	Yes	Yes		
	082	082	DuPage Medical Group - Central DuPage		Yes	Yes		
**	100	100	West Suburban Health Providers	Yes	Yes	Yes	Yes	
	112	112	St. Francis Health Care LTD	Yes	Yes	Yes		
	113	113	Pronger Smith MedicalCare Blue Island	Yes	Yes	Yes		
	113	114	ProngerSmith MedicalCareTinleyPark	Yes	Yes	Yes		
	118	118	Advanced Physician's Association	Yes	Yes	Yes		
**	129	129	WellGroup HealthPartners, LLC	Yes	Yes	Yes	Yes	

**	133	133	Gottlieb West Towns P HO	Yes	Yes	Yes	Yes	01/01/09
	155	155	Independent Physicians At Mercy	Yes	Yes	Yes		
	184	184	Resurrection Phys Provider Group	Yes	Yes	Yes		
	197	197	Northwest Suburban I PA	Yes	Yes	Yes		
	240	240	Medical CareGroup	Yes	Yes	Yes		
**	242	242	Little Company of MaryHealth Providers	Yes	Yes	Yes	Yes	
	247	247	Health Plus Physicians Organization	Yes	Yes	Yes		
	258	258	HealthSelectIPA	Yes	Yes	Yes		
	262	262	Lake County Physicians Association	Yes	Yes	Yes		
**	303	303	Saint Joseph HealthPreferred	Yes	Yes	Yes	Yes	
**	316	316	St. James PHOINC	Yes	Yes	Yes	Yes	
	332	332	Rush HealthAssociates	Yes	Yes	Yes		
	334	334	Holy Cross Health Partners,IPA	Yes	Yes	Yes		
	335	335	OakWest PrimaryPhysicians Association	Yes	Yes	Yes		
	197	348	Northwest Suburban Swedish Covenant	Yes	Yes	Yes		
**	349	349	LoyolaUniversityPhysician Foundation	Yes	Yes	Yes	Yes	
	082	355	DuPage Medical Group - MidAmerica		Yes	Yes		
**	373	373	Partners InHealth	Yes	Yes	Yes	Yes	
	374	374	St Anthony HealthNetwork	Yes	Yes	Yes	Yes	
**	418	418	St. Francis HealthPreferred	Yes	Yes	Yes	Yes	
**	433	433	Resurrection HealthPreferred	Yes	Yes	Yes	Yes	
	082	437	DuPage Medical Group -Edward		Yes	Yes		

	448	448	Affiliated Physicians GroupLLC	Yes	Yes	Yes		
	454	454	Lawndale Christian HealthCenter	Yes	Yes	Yes		
	457	457	Methodist FirstChoice	Yes	Yes	Yes		
	459	459	Mercy PhysicianAssociation	Yes	Yes	Yes		
**	462	462	Saints Mary and ElizabethHealth Preferred	Yes	Yes	Yes	Yes	

**** Catholic Directive**

The member must contact the HMO to receive a referral. Member Services will transfer all requests to the Customer Assistance Unit (CAU) so the referral can be issued for the below listed MG/IPAs. Additionally, the IPAs listed below with '**' are **Catholic Directive** IPAs (owned by an organization that is subject to the Catholic Directives**.)** These IPAs have Catholic amendment agreements and they therefore cannot issue referrals for certain family planning services (**fitting and insertion of an IUD, fitting of a diaphragm, implants, injection of DepoProvera and infertility**). These IPAs have identified other HMO physicians, either inside or outside of their IPA, who will provide these services, and who have been instructed to submit their claims directly to the HMO for payment (see attached form to be used by these providers).

Blue Cross and Blue Shield of Illinois Provider Manual, HMO Scope of Benefits Section, December 2019

Cigna Instructions for Providers and Staff

Infertility Care Management Program

Updated February 2020

Member Eligibility

- The patient's insurance eligibility is confirmed by WINFertility before authorizations are issued.
- Please fax in a copy of the Member ID Card (front and back) with outcome of initial service

NOT COVERED

Cigna does not cover ANY of the following infertility services or tests because they are considered experimental, investigational, or unproven:

- Immunological testing (e.g., antiprothrombin antibodies, embryotoxicity assay, circulating natural killer cell measurement, antiphospholipid antibodies, reproductive immunophenotype [RIP])
- Immune treatments (e.g., peri-implantation glucocorticoids, anti-tumor necrosis factor agents, leukocyte immunization, IV immunoglobulins)
- Computer-assisted sperm motion analysis
- Cryopreservation, storage, and thawing of ovarian and testicular reproductive tissue
- Culture of oocyte(s), embryo(s), less than 4 days with co-culture (i.e., coculturing of embryos/oocytes)
- Direct intraperitoneal insemination, intrafollicular insemination, fallopian tube sperm transfusion
- Endometrial receptivity testing (e.g., Endometrial Function Test™ [EFT®], integrin testing, Beta-3 integrin test, E-tegrity®, endometrial receptivity array [ERA])
- Fine needle aspiration mapping
- Hemizona test
- Hyaluronan binding assay (HBA)
- Serum inhibin B
- Sperm viability test (e.g., hypo-osmotic swelling test), when performed as a diagnostic test
- The use of sperm precursors (i.e., round or elongated spermatid nuclei, immature sperm) in the treatment of infertility
- Manual soft tissue therapy for the treatment of pelvic adhesions (WURN Technique®, Clear Passage Therapy)

Most benefit plans administered by Cigna HealthCare do not cover any of the following, even when benefits are available for infertility treatment because they are SPECIFICALLY EXCLUDED:

- Services associated with the reversal of voluntary sterilization
- Infertility services when the infertility is caused by or related to voluntary sterilization
- Donor charges, fees and services, including services associated with donor sperm and donor oocytes
- Medical services rendered to a surrogate and surrogate fees
- Commercially available over-the-counter home ovulation prediction test kits or pregnancy test kits
- Cryopreservation and storage of embryos when not undergoing covered active infertility treatment
- The patient's name must be spelled correctly and clearly.
- The correct member ID # and group # which can be found on the insurance card must be written clearly in the space provided. The member ID # may not be the patient's social security number.
- If either a member ID # or Group # changes from the previous submission to WINFertility, please inform WINFertility in writing. Please fax in a copy of the member ID card (front and back) at time of change.

WINFertility Clinical Protocols

Clinical protocols delineate the testing criteria to be used when working up the infertility patients. These studies must be completed prior to approval of induction of ovulation and assisted reproductive technology. Following the clinical protocols will reduce WINFertility's requests for additional information from the offices and make the process of authorization efficient for all.

When not clearly specified in the benefit plan, infertility is defined as ONE of the following:

- The inability of opposite-sex partners to achieve conception after at least one year of unprotected intercourse.
- The inability of a woman to achieve conception after six trials of medically supervised artificial insemination over a one year period.
- The inability of opposite-sex partners to achieve conception after six months of unprotected intercourse for a woman over the age of 35 years.

In the absence of a diagnosis of infertility, Cigna considers IVF services to be not medically necessary.

Request for Prior Authorization Form- DXPKGB (includes initial consultation and/or diagnostic workup testing)

- Complete the Request for Authorization form via fax form or online portal. Complete the form in its entirety and submit to WINFertility.
- All authorizations will be reviewed for approval or denial based on benefit eligibility and medical appropriateness.
- After completion of the Initial consult and diagnostic workup, the **Diagnostic Outcome Form** must be completed and submitted to WINFertility via fax or online portal.
- **All treatments are to be authorized by WINFertility, including surgery.**

Completing the Diagnostic Outcome Form

- **Office information:** The physician license # is the unique identifier of the physicians that practice in large groups. Since the physicians may practice in several offices, it is important to know where to return the authorizations and other office communications. This section will be pre-filled with the appropriate authorization number and fax/phone numbers for the requested office. For the diagnostic workup and faxed to your office when your request for diagnostic workup is approved. Please be sure the information is correct. If the information is not correct please be sure to notify WIN of the changes needed.
- **Patient information:** The Member ID # and date of birth are the unique identifiers of the
- patient. The patient information section will be pre-filled with the information from the payor's eligibility files. Please be sure the information is correct.
- **Service Results:** There are different types of diagnostic workup packages that are authorized through WINFertility (e.g. diagnostic package, recurrent pregnancy loss package, semen analysis). Please check the appropriate package that was performed, and submit the supporting documentation once the work-up is completed**. Male/Female voluntary sterilization status is required to complete the outcome.**
- **Sections 1-4:** These sections are specific to the type of diagnostic workup performed. Please complete the appropriate section for the authorized/performed service in its entirety.
- **Signature of Treating Physician:** The treating physician (or his designee) is required to sign and date all outcome forms if faxing and submitting a hard copy form (the online portal does not require a signature)

Completing the Medical History Form

The **Medical History Form** is to be completed and submitted to WINFertility once the member's diagnostic work up and testing is completed. The submission of the Medical History Form is required with the Diagnostic outcome form when testing was completed under the Diagnostic Workup Package (DXPKGB), unless a consult only outcome was indicated. The submission of Medical History Form is also required before review of any request for Prior authorization of treatment. Authorization for requested treatment cannot be approved without the completion of the medical history form.

The clinical protocols set the minimum requirements for patient testing prior to requesting authorization for treatment. A complete Medical History Form allows the Care Manager to determine medical necessity prior to authorizing services and reduces the need to return the request to the physician's office for the additional information.

- **Office information:** The physician license # is the unique identifier of the physicians that practice in large groups. Since the physicians may practice in several offices, it is important to know where to return the authorizations and other office communications. This section will be pre-filled with the appropriate authorization number and fax/phone numbers for the requested office, for the diagnostic workup and faxed to your office when your request for diagnostic workup is approved. Please be sure the information is correct.

- Patient information: The Member ID # and date of birth are the unique identifiers of the patient. The patient information section will be pre-filled with the information from the payor's eligibility files. Please be sure the information is correct.
- Section 1: Contact Information: The patient's most current information as supplied to your office should be completed in this section. The address and phone numbers are important for contacting the members for medication delivery.
- **Section 2: Female Infertility and Conception History:** to be completed with the available information. The Duration of Infertility field is required.
- **Section 3: Female Surgical History:** Previous voluntary sterilization must be reported as well as any reversal information. Tubal patency must be demonstrated post reversal and the couple must have unprotected intercourse for 6 month to a year, depending on the age and history of the patient, before the patient is eligible for infertility benefit.
- **Section 4: Male Surgical History:** Previous voluntary sterilization must be reported as well as any reversal information. A normal semen analysis must be demonstrated post reversal and the couple must have unprotected intercourse for 6 month to a year, depending on the age and history of the patient, before the patient is eligible for infertility benefit. Each Health plan has specific criteria that is set to determine a reversal is successful.
- **Section 5: Semen Analysis:** Prewashed semen analysis results performed within the past year should be entered here. Comprehensive (this includes morphology) semen analysis is needed prior to any fertility treatment.
- **Section 6: Preconceptual Screening:** To be completed with the available information from the workup and any prior medical history from the referring physician (Pap smear, Cervical cultures are required)
- **Section 7: Tubal/Uterine Cavity Evaluation:** Criteria for the evaluation of the tubes and uterine cavity are found in Clinical Protocols. Demonstration of tubal patency must be done prior to requesting ovulation induction.
- **Previous Cycle History:** Specific details about the patient's past treatment cycles are **required** and must include the number of prior ovulation induction cycles, prior IVF and prior donor cycles as well as the outcome of each cycle**.** The Illinois State Mandate limits the infertility benefit. These fields provide WINFertility with the information needed to keep track of ovulation induction cycles, all retrievals and the outcome of the cycles. Knowing the outcome of these cycles is **required** so that WINFertility has all the information needed to determine the member's eligibility for infertility benefits.

Request for Prior Authorization Form - Treatment

When the Physician requests treatment for the patient, check the appropriate box within the treatment categories of the acceptable global codes. All services require Prior Authorization in advance by a WINFertility Medical Director/Care Manager. Authorization is based on medical necessity and is subject to contract limitations.

- **Office information:** The physician license # is the unique identifier of the physicians that practice in large groups. Since the physicians may practice in several offices, it is important to know where to return the authorizations and other office communications. This section will be pre-filled with the appropriate authorization number and fax/phone numbers for the

requested office, for the diagnostic workup and faxed to your office when your request for diagnostic workup is approved. Please be sure the information is correct. If the information is not correct please be sure to notify WIN of the changes needed.

- **Patient information:** The Member ID # and date of birth are the unique identifiers of the patient. The patient information section will be pre-filled with the information from the payor's eligibility files. Please be sure the information is correct.
- **Signature of Treating Physician:** The treating physician (or his designee) is required to sign and date all prior authorization forms if faxing and submitting a hard copy form (the online portal does not require a signature)

After a review of the Medical History Form and any prior Outcome Forms of the previous cycles, the Care Managers determine the medical necessity of the request. Upon approval of a service, the authorization number will be generated and notification will be sent to your office along with the appropriate Outcome Form for that service.

The WINFertility authorization number will have a start date & expiration date. These dates will be noted on the form. Different bundled packages have different date ranges. For example, an IVF cycle approval is typically a three-month date range. A diagnostic package is also a three-month date range. This allows you to have time to start and finish testing and/or treatment.

Once an authorization has expired, if the service has not been performed, the outcome form for that authorization must be completed with the Service Not Rendered box checked. A new Request for Prior Authorization form may then be submitted to WINFertility for an authorization with updated date range.

Completing Treatment Outcome Forms

When requesting new treatment, the outcome of the **previously authorized services** must be reported to WINFertility before additional services will be approved.

Treatment outcomes on all authorized services must be reported to WINFertility. This includes patients who do not return to your office for additional treatment or for those who achieve a pregnancy.

- **Office information:** The physician license # is the unique identifier of the physicians that practice in large groups. Since the physicians may practice in several offices, it is important to know where to return the authorizations and other office communications. This section will be pre-filled with the appropriate fax/phone numbers for the requesting office and faxed to your office when the outcome of your previous service has been received. Please be sure the information is correct.
- **Patient information:** The patient ID # and date of birth are the unique identifiers of the patient. The patient information section will be pre-filled with the information from the payor's eligibility files. Please be sure the information is correct.
- **Service Results:** This section contains the options for **Services Not Rendered, Completed Cycles and Cancelled Cycles.** Please check the appropriate box for the outcome of the authorized service and follow the instructions for the sections to be completed.

Infertility Prescription Forms

All Infertility Prescription Forms must be faxed directly to WINFertility to (877) 369-4560. Do not send the patient directly to the pharmacy. Infertility medications require prior authorization by WINFertility, and in some cases may require the physician's office to also complete a Prior Authorization through Cigna directly by calling 800-244-6224. The Tax ID and DEA# must be included on the form.

Not all Cigna members go through WINFertility. Please process their prescriptions as you would for non-WIN patients. These groups below have Express Scripts (ESI) as their Pharmacy Benefit Manager (PBM). A Clinical Authorization still must be obtained from WIN for ESI to authorize the medications.

- Quality (3181456)
- Local (2457474)
- Teachers (2457482)
- College (2457490)
- DHL Holdings (3313268)

Infertility Prescription Form: This form is to be used for all cycles except donor egg. All prescriptions must be submitted on this form. Complete all patient information; it is especially important the telephone contact numbers are current for all patients. Patients will be contacted by WINFertility within 24 hours of receipt and authorization by WINFertility for processing. A Pharmacy should also be selected for the dispensing of the medication. The in- network pharmacies are listed on your quick reference guide and are subject to change. These are the only pharmacies you may use.

Infertility Donor Cycle Prescription Form:
This form is to be used only for all donor egg cycles. The Prescription – Donor section represents the WINFertility preferred formulary. Please complete this section for all donor medications. The Prescription Recipient section represents other commonly prescribed pharmaceuticals. Please complete this section for all recipient's medications. If you would like the donor medication shipped to your office please indicate so on this form.

- **WINFertility Preferred Formulary** There are specific drugs that are on the WINFertility Preferred Formulary, these drugs are only used for infertility. In the rare instances that medical necessity requires use of a WINFertility non-preferred drug a Medical Necessity Form will be faxed to your office for completion.
- **Dispensing Gonadotropins:** Gonadotropins are manufactured in various package sizes. The specific package size combination dispensed by the pharmacy will be calculated to minimize quantity of patient injections and drugwaste.
- **Commonly Prescribed Pharmaceuticals:** These drugs are commonly prescribed in a treatment cycle for infertility but can be used for treatment of other diagnosis.

Infertility Prescription Refills

The member will call WINFertility at 877-528-0300 for all refills.

Do not call or go directly to the pharmacy for refills. All infertility prescription refills must be faxed directly to WINFertility at 877-444-4942. Medication refills require additional prior authorization by WINFertility. This does not apply to the aforementioned groups.

Process for coverage (this is applicable to those are fully insured and meet criteria as outlined in the Illinois Fertility State Mandate):

- Same sex couples and single females must still meet the definition of infertility as outlined in the Illinois mandate.
- At least one of the mandated requirements must be met for the member to have access to the infertility benefit:
- Unable to conceive after one year of unprotected sexual intercourse for females under 35; 6 months for females 35 andolder
- The presence of voluntary sterilization (such as vasectomy or tubal
- ligation) is considered 'protection' for sexual intercourse, and thus does not meet the definition of infertility. In the event that a voluntary sterilization has been reversed successfully, infertility benefits will be available if the member's current clinical situation meets the definition of infertility.
- Is unable to sustain a successful pregnancy
- Has been diagnosed by a physician as having a medical condition that renders conception impossible through unprotected sexual intercourse; or
- Has undergone one year of medically based and supervised methods of
- conception, including artificial insemination, which a physician has determined to have failed and are not likely to lead to a successful pregnancy. (e.g. Have proof of 1 year (or the required minimum) of IUI's with donor sperm (from a donor bank).

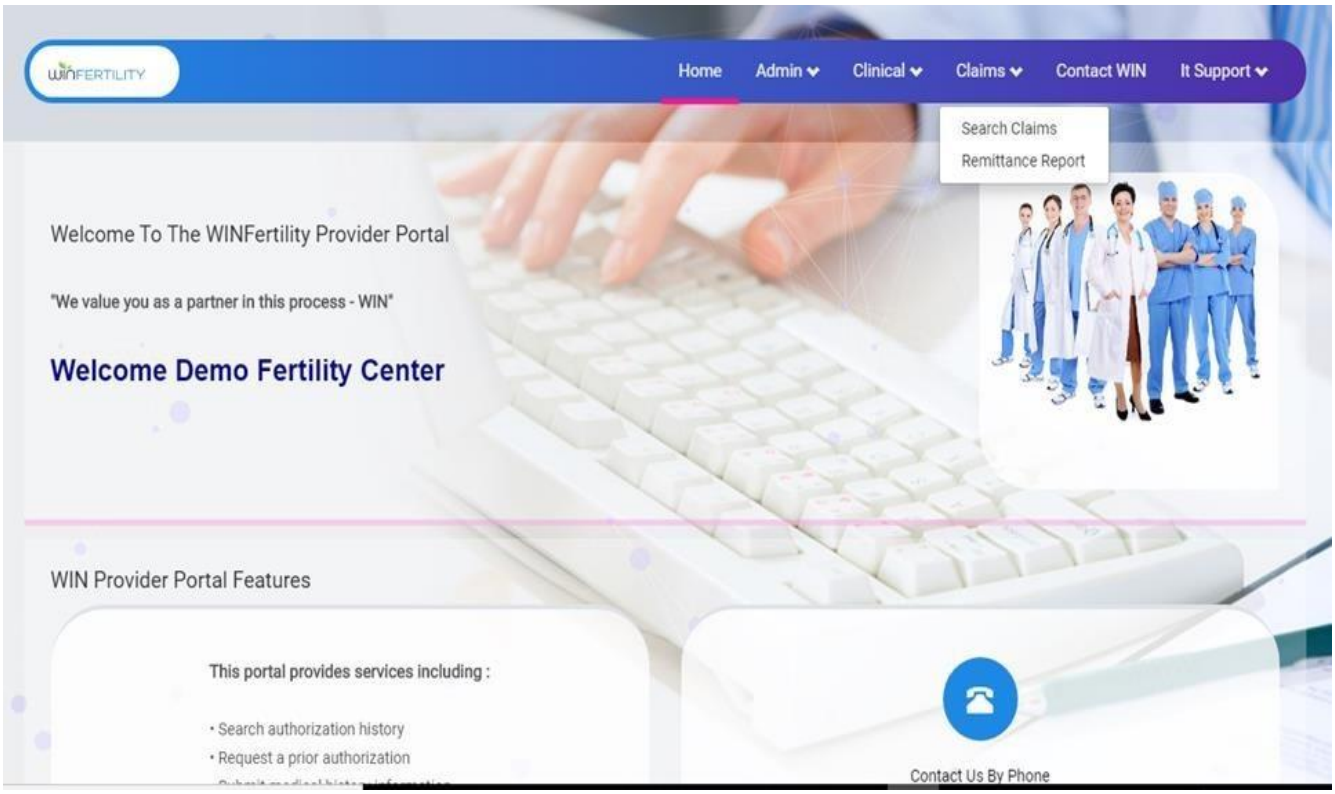
Eliminate the Administrative Burden of Faxing and Mailing Documents

Electronic Data Interchange (EDI)

- WIN uses Emdeon for EDI transactions:
- Payer ID: 13413
- Payer Name: WINFertility

Provider Portal (www.winfertilityprovider.com)

- Contact WINFertility to be set up on the Provider Portal to access features such as:
- Prior Authorization Submission
- Outcome and Medical History Entry
- Receive Notifications
- Check Claim Status
- Upload Documents
- And MORE!



Credentialing/Re-Credentialing Policy

WIN's credentialing program is consistent with the guidelines of the National Commission on Quality Assurance (NCQA). All licensed professionals participating in WINFertility's network are required to complete the credentialing/re-credentialing process that follows. This process is designed to ensure that all information submitted by licensed health care professionals is accurate and complete.

WIN's Credentialing Program is governed by WIN's Credentialing Policies and Procedures, maintained by WIN's Credentialing Department with oversight by WIN's Credentialing Committee and Consulting Medical Director. This Program includes the review and approval of required data related to licensure, certification, education, work history, and standing within certain agencies and professional societies. WIN will do so via primary source verification where applicable and required under NCQA standards. All primary source verification will be completed within 180 calendar days of attestation date or less prior to Credentialing Committee approval date during both the initial credentialing and re-credentialing process, unless otherwise noted. All credentialing records shall be kept in secured files.

WIN will ensure that the Credentialing Program is conducted in a nondiscriminatory manner. Decisions will not be based on the practitioner's age, race, gender, gender identification, ethnicity or national identity, religion, sexual orientation, type of specialty services performed or type of procedure or patient in which the practitioner specializes. WIN will follow a systematic approach to allow qualified and appropriate licensed professionals to enter its network, and to maintain their network status. WIN will conduct periodic audits at least annually of credentialing files in process, approved, and denied, as well as any practitioner complaints to ensure practitioners are not discriminated against.

Per WIN policy, all credentialing files will undergo initial verification and review no later than every three years (36 months) to ensure that the information submitted is accurate, complete and continues to meet the standards for approval by WIN's Credentialing Committee. On-going monitoring of sanctions is conducted both monthly for OIG/SAM/NPDB and annually via WIN's Midterm review/attestation process.

Criteria for Physician Network Participation

WIN's physician network is developed by invitation to selected physicians or recommendation by WIN's Medical Advisory Board members. The initial goal is to attract an appropriate number of qualified physicians distributed geographically in specific local markets. Subsequent recruitment efforts would be based on WIN's knowledge and understanding of market needs and payer demand.

To be considered for membership in WIN's network, each physician must meet the following minimum criteria:

- Board Certification or board eligibility by ABOG and/or ABMS for all MD practice members
- Board Certification or board eligibility by ABOG in Obstetrics and Gynecology
- Board Certification or fellowship training in the subspecialty of Reproductive Endocrinology
- Osteopathic Obstetricians and Gynecologists must be board certified or board eligible by AOA, and renew certification every six years. However, prior to 2002 DO's are not required to renew certification and possess lifelong certification
- Current, active, in good standing and unrestricted license to practice medicine. No loss of license in any state
- Professional liability insurance of no less than $1,000,000/$3,000,000 insured by a carrier approved by the state where the physician is practicing (unless state mandates lower or higher limits)
- Limited professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner within last 10 years
- Current DEA license and state Control Substance license where applicable
- Formal hospital affiliations with privileges
- Current Curriculum Vitae
- No work history gaps of greater than 6 months without valid explanation. (i.e., family leave, job search, illness)
- Any other criteria reasonably established and reviewed by WIN on an ongoing basis
- Cultural Competency Training

For questions regarding WIN's credentialing process please contact Cindy Gisonno at (914) 412-3064 or via email @CGisonno@WIN-Healthcare.com.

Provider Termination

Regulatory Requirements

- Members are notified in writing of any significant changes in the availability or location of covered services or any other significant changes in information regarding their medical care at least ninety (90) business days prior to the effective date of such changes. All impacted customers are sent a "Provider Termination Letter"
- WIN follows termination procedures as set forth in the provider agreement and in accordance with accreditation guidelines. Upon termination, WIN acts to immediately remove the provider from network participation

Notification Timelines

- WINFertility Provider Relations department notifies the Credentialing Division of any changes in provider location or provider termination

- Notification is sent via postal services by the Credentialing Division to all affected members
- Members affected by the change in location or provider termination are notified in writing at least ninety (90) business days before the effective date
- In the event that adequate notice is not provided to WINFertility by the provider, the member notification letter is mailed as soon as possible but no later than seven (7) working days from the date WINFertility received notification of change
- In the event of a natural disaster or emergency, WINFertility shall provide notice to members as soon as possible, but no later than fourteen (14) business days. To receive this transition of care service you must submit a request in writing within 30 days of this notification or call: WINFertility, Inc.

Attention: Medical Management Department 1 American Lane, Terrace Level
Greenwich, CT 06831
(877) 528-0300

Termination without Cause

- Provider agreements may be terminated by either Party with at least ninety (90) days prior written notice to the other Party

Termination for Breach of Contract

- Termination for cause is thirty (30) days

Provider Termination

Member Notifications

- Notifications are written at a reading level understandable to WINFertility members in threshold languages. Terminating Medical Groups, Clinics and WIN Network Practitioner notification letter provide the following information:
- Reason for termination
- Effective date of the termination
- Name of the terminating Clinic or WIN Network Practitioner
- Description of how the termination will affect the member's access to covered services
- A copy of in-network providers will be included in the letter to ensure each member is updated with other WIN providers to choose from
- Explanation of out of network
- Directions for Continuity of Care
- Ways to find new in-network provider

Change of Location

- Notification letter is sent to all WIN members assigned to the WIN Network Practitioner including language and non-discrimination notices

Termination

- Notification letter is sent to all members assigned to the WIN Network Practitioner

Oversight

- WIN maintains the Provider Mailing Termination Log of those Providers that have notified members of a change in location or termination. This is done to ensure that members are appropriately notified by the Provider. A copy of all notifications and the list of members assigned to the Provider are placed in the credentialing and provider's files

Members' Rights and Responsibilities

We treat our members with respect and dignity. We don't discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation or any other basis prohibited by law. Members have responsibilities too. Together we can advise members of their rights and responsibilities. Review the member rights and responsibilities below.

WIN's members have the right to information related to their treatment or treatment options in a language they can understand. This includes, but is not limited to:

- The freedom to exercise all member rights without any adverse effect on the member's treatment by WINFertility or our participating providers
- Names of care managers and participating providers
- Copies of medical records as allowed by law
- A description of their rights and responsibilities as members, including the right to refuse treatment
- Information about the cost to a member if the member chooses to pay for a service that is not covered
- Procedures for obtaining services, including authorization requirements
- What treatment choices or types of care are available to the member, and the benefits or drawbacks of each choice

Members have a right to respect, fairness and dignity. This includes, but is not limited to:

- An ability to receive covered services without concern about payer source, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay or ability to speak English
- Quality medical services that support personal beliefs, medical condition and cultural background
- Interpreter services for members who are Limited English Proficient (LEP), have impaired hearing, or have requested written information in an alternative format such as Braille
- The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience

Members' Rights and Responsibilities

- Receiving information from their provider about appropriate or medically necessary treatment options and alternatives for their condition(s) regardless of cost or benefit coverage in a manner appropriate to their ability to understand

Members have a right to participate in decision making about their health care, and/or have a representative facilitate care or treatment decisions when necessary. This includes, but is not limited to:

- Choosing a WIN participating Reproductive Endocrinologist (REI) to help with planning and coordinating care
- Timely access to providers and care from a specialist when it is needed; timely access to prescriptions from a network pharmacy
- The right to know about all treatment options, no matter what they cost or whether they are covered
- The right to be told about any risks involved in care
- The right to be told in advance if a proposed care or treatment is part of a research experiment and the right to refuse experimental treatments ▪ Request specific, condition-related information.
- Request information about medical procedures and who will perform them
- Deciding who should be in attendance at treatments and examinations
- Participate in health care decisions including refusing a treatment
- Written notification when health care services are approved, denied or modified Notification is accompanied by instructions on how to file a complaint or grievance.

Members have a right to confidentiality and privacy. This includes, but is not limited to:

- Privacy and confidentiality of health care information. Information will be distributed only as allowed by law
- The right to receive a copy of their medical records and to ask that additions or corrections be made to their records
- The right to ask how their health care information has been given out and used for nonroutine purposes
- The right to talk to health-care professionals and care managers privately

Members' Rights and Responsibilities

Members have a right to report concerns to WINFertility. This includes, but is not limited to:

- Filing a complaint or grievance
- Providing recommendations for changes to policies and services
- The right to a detailed explanation of a denial of care

Member Responsibilities

- Knowing the name of their assigned Provider and/or Care Manager
- Familiarizing themselves with their coverage and the rules they must follow to receive care
- Informing WIN of any changes in eligibility, or any other information that may affect membership, healthcare needs or access to benefits
- Respecting the healthcare professionals providing service
- Sharing any concerns, questions or problems with WINFertility
- Providing all necessary health related information needed by the professional staff providing care, and requesting more explanation if a treatment plan or health condition is not understood
- Following instructions and guidelines agreed upon with the health professionals giving care
- Protecting their member identification card and providing it each time they receive services
- Disclosing other insurance they may have and/or applying for other benefits they may be eligible for
- Scheduling Appointments
- Arriving for appointments on time
- Notifying the healthcare professionals if it is necessary to cancel an appointment

Medical Management

Our Medical Management Program encompasses activities directed toward prospective and retrospective utilization review of fertility management services and integrated care management. Care management services assist physicians with members who have special needs, complex health and/or high-risk infertility issues. WIN does not perform concurrent reviews.

Prospective review (prior authorization) determines the medical necessity and appropriateness of the service before it's provided.

Retrospective review involves assessment of the appropriateness of medical services after the services have been provided.

We use evidence-based practices to identify members at high risk. We offer them care management services built upon a collaborative relationship with a single clinical case manager, their PCP when applicable and reproductive endocrinologists (REI). This relationship continues throughout the care management engagement. We also offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support.

To support our care management activities, we use our proprietary health risk assessment, questionnaires and predictive modeling software. A customized care management application (ATS) enables our care management team to work closely with members, their families and providers to help improve clinical outcomes and enhance the quality of life for members.

The functionality of the care management software includes:

- Case finding tools
- Outreach questionnaire
- Integrated clinical assessments
- Integrated care plan
- Correspondence
- Condition-specific assessments
- Member satisfaction survey
- Audit tools
- Reporting (e.g., tracking of member outcomes)

Our utilization management and quality management staff work with providers, monitoring the care provided to members and performing the following functions:

- Coordination of member services, including:
- Detecting inappropriate patterns of care (e.g. over- or under-utilization of services, including pharmacy)
- Identifying diagnoses or multiple co-morbidities that place members at risk for serious consequences
- Monitoring compliance with treatment protocols, including:

- Untreated co-morbid conditions
- Gaps in care, such as a failure to fill prescribed medications or get a flu shot based on evidence-based guidelines
- Assessing provider performance, including:
- Adherence to evidence-based clinical guidelines, including prescribing patterns
- The delivery of care or services which, if improved, could enhance member safety and health outcomes
- The provision of Inter Rater reliability testing

Medical Necessity

All services provided to members must be “Medically Necessary” and delivered at the appropriate level of care.

A service or benefit is “Medically Necessary” if it’s compensable under the Medical Assistance Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age

Determination of Medical Necessity for covered care and services, whether made on a prior authorization or retrospective review, or exception basis, must be documented in writing. The determination is based on medical information provided by the PCP when applicable and reproductive endocrinologist (REI), as well as any other providers, programs, and/or agencies that have evaluated the member. All such determinations must be made by qualified and trained health care providers.

To support prior authorization and retrospective review decisions, we use nationally recognized evidencebased criteria with input from health care providers in active clinical practice. We apply these criteria on the basis of medical necessity and appropriateness of the requested service, the individual member’s circumstances and applicable contract language concerning the benefits and exclusions.
WIN reviews Protocols & Guidelines criteria annually for appropriateness to our needs and change as applicable in order to reflect current medical standards. The annual review process involves appropriate practitioners in developing, adopting or reviewing criteria. Prior Authorization and retrospective review requests are presented to the designated medical director for review when the request does not clearly meet criteria applied as defined above. Before making a determination of medical necessity, the reviewing medical director may contact the requester to discuss the case. The prescribing or treating practitioner may request a peer review to discuss a medical necessity denial with a medical director reviewer.

Medical Management

Information Required for Prior Authorization and Retrospective Review

Health care services and items must be medically necessary and provided in an appropriate, effective, timely and cost efficient manner. Generally, a member's REI is responsible for initiating and coordinating a request for prior authorization. Providers are responsible for complying with our prior authorization policies and procedures and for getting an authorization number to ensure reimbursement of claims. Information in the prior authorization request must validate the medical necessity for covered care and services, procedures and level of care and medical or therapeutic items.

A request for authorization must also include the following information:

- Current, applicable codes (e.g., Current Procedural Terminology)
- Name, date of birth, sex and identification number of the member
- Primary care or treating provider
- Name, address, phone and fax number and signature, if applicable of the referring provider
- Name, address, phone and fax number of the consulting provider
- Problem/diagnosis, including the ICD-9 code
- Reason for the referral
- Clinical information such as progress notes, consultation reports, a letter of medical necessity, reports of laboratory and imaging studies, and treatment dates, as applicable for the request.

We adhere to the following timeframes when notifying REIs, prescribing clinicians and members of prior authorization, and retrospective review decisions:

Type of Decisions	Decision	Initial Notification	Written Confirmation
Urgent Precertification	24 hours from receipt of Request*	24 hours from receipt of request	24 hours from initial notification
Non-Urgent Precertification	3 business days from receipt of the request	3 business days from receipt of the request	3 business days from initial notification
Retrospective Review	30 calendar days from receipt of the request	30 calendar days from receipt of the request	30 calendar days from receipt of the request

*The timeframes for decisions and notification may be extended if additional information is needed to process the request. If we need more facts, documents or information to make a decision, we'll request it from the appropriate practitioner.

Denials

We notify the prescribing practitioner, member's reproductive endocrinologist (REI) and member in writing of any decision to deny, a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. Our medical director conduct's a medical review for each case identified as a potential denial of authorization.

The requesting physician may be asked to submit more information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to deny, modify an existing or pending service.

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. WIN does not specifically reward practitioners or other individuals for issuing denials of coverage or care or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

The attending or referring physician may dispute the finding of the medical director informally by phone (Peerto-Peer) or formally in writing. If the finding of the medical director is disputed, a grievance may be filed according to the established grievance process.

Peer-to-Peer

Our medical directors participate in the utilization review process and conduct clinical review. They're available to discuss review determinations with attending physicians or other ordering providers. We'll notify practitioners/providers verbally, at the time of notification of the denial, that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer.

We provide, within one business day of a request by the attending physician or ordering practitioner, the opportunity to discuss the denial decision:

- With the medical director making the initial determination; or
- With a different medical director if the original medical director cannot be available within one business day; and
- If a peer-to-peer conversation or review of additional information does not result in a certification, the denial letter informs the practitioner/provider and member of the right to initiate an appeal and the procedure to do so

Medical Claims Review

We identify certain claims to determine whether services were delivered as prescribed and consistent with our payment policies and procedures. In these instances, our medical claims reviewers determine whether the documentation provided supports the billing, whether billed charges are necessary and reasonable, and identify non-covered supplies and services as well as inappropriate and undocumented charges. The medical claims reviewers report any cases of potential fraud or abuse to our Compliance Department for review.

Quality Management

WIN's Quality Improvement Program is a continuous quality improvement process consist of all-inclusive quality assessments and performance improvement activities. These activities proactively review our clinical and operational programs and processes to identify opportunities for continued improvement utilizing the PDSA model of care.

The goal of our Quality Improvement Committee is to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary

The use of encounter data, ad-hoc internal reports, URAC, ASRM & state guidelines in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of our quality improvement process. WIN's QI Program uses an integrated and collaborative approach, involving our entire senior management team, all functional areas and all committees from the Board of Directors to the Member Advisory subcommittee. Our chief medical director oversees the QI program. The medical director is supported in this effort by our Clinical Services, Compliance, Utilization Management, Credentialing, Provider Networking and Operation divisions.

Our Compliance division, under the direction of the VP of Clinical Services, develops and implements an annual work plan, which specifies projected quality management activities. Based on the work plan, we conduct an annual QI Program Evaluation both of which is reviewed/approved by the Board of Directors.

Our Utilization Management (UM) program manages monitors, evaluates and improves the care and services provided to our members. Our UM program is designed to:

- Educate members and providers about the appropriate utilization of care/service delivery systems
- Assess member and provider satisfaction with the processes
- Identify opportunities to optimize members' health outcomes
- Manage health care costs

WIN's UM program is integrated with its quality management program, both of which are dedicated to ensuring high quality, cost-effective, outcomes-oriented health care for our members. We encourage all providers to participate in medical committees and quality projects.

Complaint Process

The Department of Human Services defines “complaint” and “grievance” as two separate and distinct types of issues. Members and their representatives (including providers) may file a complaint or grievance if they are not able to resolve issues through informal channels.

“Complaint” is a dispute or objection regarding a participating health care provider or the coverage, operations, or utilization management policies. Complaints include, but are not limited to:

- A denial because the requested service/item is not a covered benefit
- Failure of WIN to meet the required timeframes for providing a service/item
- Failure of WIN to decide a complaint or grievance within specified timeframes
- Denial of payment by WIN after a service has been delivered because the service/item provided is not a covered service/item for the member

“Grievance” is a request to have WIN reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. Members or their representatives (including providers) may file a grievance. A grievance may be filed regarding grievance decision to:

- Deny, in whole or in part, payment for a service/item
- Deny or issue a limited authorization of a requested service/item, including the type or level of service/item
- Reduce, suspend or terminate a previously authorized service/item

No Retribution

- WIN shall not take any action with respect to a patient or a health care provider that is intended to penalize the insured, the insured’s designee, or the insured’s health care provider from undertaking an appeal, dispute a resolution, or judicial review of an adverse determination

Tracking and Trending of Complaints

- A log will be kept of all member and practitioner complaints and appeals to track the type and frequency. Identified trends in complaints identified in the complaints and appeals log will be brought to the attention of the Consulting Medical Director and reviewed at subsequent QI Committee meetings.

Documentation of Complaints

- Documentation of complaint review decisions will be completed on the Complaint Form and entered in the Complaint Tracking Log by the Director of Quality Improvement or designee. The UM Complaint Form will include the individuals reviewing the complaint and/review, facts and documented evidence used in the review, and the rationale for the decision. Documentation regarding first and second level complaints will be filed with the original complaint form.

For questions regarding filing a complaint/grievance, please contact Shantell Robinson at (914) 3810300 Ext. 3005 or via email @srobinson@win-healthcare.com

Fraud Waste and/or Abuse (FWA)

We employ a variety of methods to detect potential fraud and abuse, including monitoring claim edits, prior authorization, utilization management, quality management audits and provider profiling. We have also developed algorithms to detect potential claims upcoding, with follow-up procedures for chart audits as appropriate. Also, our business software applications use historical claims information to detect and correct questionable billing practices.

Claims that reach an adjudicated status of "pay" will receive a control edit, which includes, but is not limited to:

- Verification of member eligibility
- Verification of covered services
- Validation of provider IDs and active status in practices and locations through automated matches with provider master databases
- Determining whether services are within the scope of a provider's specialty
- Valid prior authorization
- Submission of required documentation
- Excessive or unusual services based on the member's age or gender
- Duplication of services
- Invalid procedure codes
- Duplicate claims
- Match of billed procedure codes with inclusions/exclusions list in each treatment type
  - Validations for timely filing

Fraud and Abuse Examples

Examples of health care provider fraud and abuse are:

- Billing or charging members for services that are covered
- Offering members gifts or money to receive treatment or services
- Providing members with treatment or services that they do not need
- Physical, mental or sexual abuse by medical staff

Examples of member fraud and abuse are:

- Members selling or lending their identification cards to other people
- Members abusing their benefits by seeking drugs or services that are not medically necessary