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# Florida Medicaid Provider Manual

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# I. Overview

## **About WellCare**

WellCare Health Plans, Inc., doing business as Staywell Health Plan of Florida for Medicaid, and HealthEase of Florida Inc. (WellCare) provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid and Medicare, including prescription drug plans and health plans for families, and the aged, blind and disabled. WellCare's corporate office is located in Tampa, Florida. As of June 30, 2011, WellCare served approximately 2.4 million members. Our experience and commitment to government-sponsored healthcare programs enable us to serve our members and providers as well as manage our operations effectively and efficiently.

## **Purpose of this Manual**

This Provider Manual is intended for WellCare-contracted (participating) Medicaid providers providing health care service(s) to WellCare members enrolled in a WellCare Medicaid Managed Care plan. This manual serves as a guide to the policies and procedures governing the administration of WellCare's Medicaid plans and is an extension of and supplements the Provider Participation Agreement (Agreement) between WellCare and health care providers, who include, without limitation: physicians, hospitals and ancillary providers (collectively, Providers). **This manual replaces and supersedes any previous versions dated prior to January 1, 2012 and is available on WellCare's website at [www.welcare.com/Provider/ProviderManuals](http://www.welcare.com/Provider/ProviderManuals).** A paper copy, at no charge, may be obtained upon request by contacting Customer Service (Provider Services) or your Provider Relations representative.

In accordance with the Policies and Procedures clause of the Agreement, participating WellCare Medicaid providers must abide by all applicable provisions contained in this manual. Revisions to this manual reflect changes made to WellCare's policies and procedures. Revisions shall become binding thirty (30) days after notice is provided by mail or electronic means, or such other period of time as necessary for WellCare to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by WellCare in the form of Provider Bulletins and will be incorporated into subsequent versions of this manual. Provider Bulletins that are state specific may override the policies and procedures in this manual.

## **WellCare's Medicaid Managed Care Plans**

WellCare has contracted with the Florida Agency for Health Care Administration (Agency) to provide Medicaid and CHIP managed care services. These products are offered in select markets to allow flexibility and offer a distinct set of benefits to fit member needs in each area. The health plans offered are:

### **HealthEase and Staywell (Medicaid)**

HealthEase of Florida, Inc., and WellCare of Florida, Inc., doing business as Staywell, serve both adults and children eligible to participate in Florida's Medicaid program. These plans offer members more benefits and coverage than traditional Medicaid at no additional cost. Members may choose their Primary Care Provider (PCP) from a network of participating providers, including family doctors, pediatricians and internists.

## **HealthEase and Staywell (Medicaid) Eligibility**

Eligibility is solely determined by the Agency. Three basic groups eligible for Medicaid are:

- Supplemental Security Income (SSI) recipients;
- Children and families, including women; and
- Aged, blind, and disabled persons, including those needing institutional care (these programs are also referred to as “SSI related” Medicaid).

An individual must meet specific eligibility requirements in order to be eligible for Medicaid. Each program has specific income and asset limits that must be met.

The Agency requires that most Medicaid recipients must enroll with a managed care plan. Eligible recipients are given thirty (30) days from the date that Medicaid eligibility begins to select a Medicaid managed care option. If recipients do not select an option within thirty (30) days, they are automatically assigned to a managed care plan.

## **HealthEase and Staywell (Medicaid) Core Benefits and Services**

As of the date of publication of this manual, the following core benefits and services (Covered Services) are provided to WellCare’s Florida Medicaid members:

- Ambulatory Surgical Center Services;
- Birth Center Services;
- Chiropractic Services;
- Child Health Check-Up Services (also known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and special services);
- Community Behavioral Health Services;
- County Health Department Services;
- Durable Medical Equipment and Medical Supplies;
- Dialysis Services, including freestanding dialysis centers;
- Emergency Medical Services;
- Family Planning Services;
- Hearing Services, including Hearing Aids for Members Under Age twenty-one (21);
- Home Health Services;
- Immunizations;
- Independent Laboratory Services;
- Inpatient Hospital Services;
- Medical Services, including but not limited to, those provided by Physicians, Physician Assistants, Advance Practice Registered Nurses (ARNPs), Federally Qualified Health Centers (FQHCs), Primary Care Centers, Rural Health Clinics (RHCs);
- Licensed Midwife Services;
- Optometric Services;
- Outpatient Hospital Services;
- Podiatry Services;
- Portable X-ray Services;
- Prescription medications;
- Primary Care Case Management Services;
- Targeted Case Management;
- Therapy Services including Occupational, Physical, Respiratory and Speech; and
- Vision Services. For the most up-to-date information on Covered Services, refer to the Agency’s website at [www.ahca.myflorida.org](http://www.ahca.myflorida.org).

### **HealthEase and Staywell Kids**

HealthEase and Staywell Kids provide affordable health coverage to children in communities across the state and is a part of the Florida Healthy Kids program. Florida Healthy Kids is a public/private partnership that provides comprehensive health insurance for school-age children ages five (5) through eighteen (18) in the state of Florida.

### **HealthEase and Staywell Kids Eligibility**

Eligibility for the Healthy Kids program is solely determined by the Agency. Criteria include:

- Be five (5) to eighteen (18) years of age;
- Uninsured;
- A U.S. citizen or a qualified alien;
- Not the dependent of a State employee; and
- Applicant child:
  - May not have access to employer sponsored insurance; or if such access exists, the cost exceeds five percent (5%) of the family's income;
  - Has not voluntarily lost employer coverage within six (6) months of application; and
  - Is ineligible for Medicaid or the Children's Medical Services Network (CMSN) as defined by the Florida KidCare Act, Florida Statutes 409.810-409.820).

### **HealthEase and Staywell Kids Core Benefits and Services**

As of the date of publication of this manual, the following core benefits and services (Covered Services) are provided to WellCare's Florida HealthEase and Staywell Kids members:

- Anesthesia Services;
- Behavioral Health Services;
- Chiropractic Services;
- Diagnostic Testing;
- Durable Medical Equipment (DME) and Prosthetic Devices;
- Emergency Transportation;
- Hearing Screening (Routine);
- Home Health Services;
- Hospice;
- Inpatient Services, including Hospital Inpatient Medical and Surgical Care;
- Nursing Facilities;
- Office visits for minor illnesses and accident care, including Specialist office visit (if referred by PCP);
- Organ Transplants;
- Outpatient Physical, Occupational, Respiratory and Speech Therapies;
- Pharmacy Coverage;
- Prenatal care and delivery;
- Substance Abuse rehabilitation and treatment;
- Surgeon's fees;
- Unauthorized use of emergency services;
- Vision Services including routine screenings and refractions/corrective lenses; and
- Well-Child care and school physicals.

- For the most up-to-date information on Covered Services, refer to the Agency's website at [www.healthykids.org](http://www.healthykids.org).

### **Provider Services**

Providers may contact the appropriate departments at WellCare by referring to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

Provider Relations representatives are available to assist in many requests for participating WellCare providers. Contact your local market office for assistance.

### **WellCare.com**

On WellCare's website [www.wellcare.com](http://www.wellcare.com), providers have access to a variety of easy-to-use tools created to streamline day-to-day administrative tasks with WellCare.

Additional public resources found on the website include:

- Provider Manuals
- Quick Reference Guides
- Clinical Practice Guidelines
- Clinical Coverage Guidelines
- Forms and Documents
- Pharmacy and Provider Look-Up (Directories)
- Newsletters
- Training Materials and Job Aids
- Member Rights and Responsibilities
- Privacy Statement and Notice of Privacy Practices

Registration is required to utilize certain key features outlined below.

### **Key Features and Benefits of Registering for WellCare's Provider Portal**

The secure, online Provider Portal of WellCare's website provides immediate access to what providers need most. All participating providers who create a log-in and password using WellCare's Provider Identification (Provider ID) number can leverage the following features:

#### **Claims Submission Status and Inquiry**

- Submit a claim
- Check the status of a claim
- Customize and download reports

**Member Eligibility and Co-Pay Information** – Verify member eligibility and obtain specific co-pay information.

**Authorization Requests** – Some providers may submit authorization requests online, attach clinical documentation and check authorization status. Providers may also print and/or save copies of the authorization form.

**Pharmacy Services and Utilization** – View and download a copy of WellCare's preferred drug list (PDL), see drug recalls, access pharmacy utilization reports and obtain information about WellCare pharmacy services.

**Provider News** – View and download the latest announcements to providers.

**Provider Inbox** – A provider-specific inbox to receive notices and key reports regarding claims, eligibility inquiries and authorization requests.

**Your Registration Advantage**

The secure, online Provider Portal of the WellCare website allows providers to have as many administrative users as needed and can tailor views, downloading options and e-mail details. Providers may also set-up individual sub-accounts for your staff, keeping separate billing and medical accounts. Once registered for WellCare's website, providers should retain log-in and password information for future reference.

**How to Register**

To register, refer to the Florida Medicaid *Provider How-To Guide* which may be found on WellCare's website at [www.wellcare.com/Provider/job\\_aids](http://www.wellcare.com/Provider/job_aids). For more information about WellCare web capabilities, please contact Provider Services or contact Provider Relations to schedule a website in-service.

## II. Provider and Member Administrative Guidelines

### Provider Administrative Overview

This section is an overview of guidelines for which all participating WellCare Medicaid Managed Care providers are accountable. Please refer to the Provider Participation Agreement (Agreement) or contact your Provider Relations representative for clarification of any of the following.

Participating WellCare Medicaid providers, must in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973;
- Agree to cooperate with WellCare in its efforts to monitor compliance with its Medicaid contract(s) and/or Agency rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations;
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to WellCare members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care. [42 C.F.R. § 422.504(a)(3)(iii).];
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the Agency and WellCare guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician extender title (examples: MD, DO, ARNP, PA) to members and to other health care professionals;
- Honor at all times any member request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any member in need of health care services;
- Maintain the confidentiality of member information and records;
- Respond promptly to WellCare's request(s) for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all WellCare's policies governing content and confidentiality of medical records as outlined in *Section VI. Quality Improvement* and *Section IX. Compliance*;
- Ensure that: (a) all employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement between provider and WellCare; (b) to the extent physician maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and (c) physician maintains written agreements with all contracted physicians or other health care

practitioners and providers, which agreements contain similar provisions to the Agreement;

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the member or the requesting party at no charge, unless otherwise agreed;
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen;
- Not discriminate in any manner between WellCare Medicaid members and non-WellCare Medicaid members;
- Not deny, limit or condition the furnishing of treatment to any WellCare member on the basis of any factor that is related to health status, including, but not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability;
- Freely communicate with and advise members regarding the diagnosis of the member's condition and advocate on member's behalf for member's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are covered services;
- Identify members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to WellCare-sponsored or community-based programs;
- Must document the referral to WellCare-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.

### **Excluded or Prohibited Services**

Providers must verify patient eligibility and enrollment prior to service delivery. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, such as non-emergency transportation, are administered outside of the managed care program.

Excluded services are defined as those services that members may obtain under the Florida Medicaid plan, and for which WellCare is not financially responsible. These services may be paid for by the Agency on a fee-for-service basis or other basis. Providers are required to determine eligibility and Covered Services prior to rendering services. In the event the service(s) is(are) excluded, you must submit reimbursement for services directly to the Agency. In the event the service(s) is(are) prohibited, neither WellCare nor the Agency is financially responsible. For more information on prohibited services, refer to the Agency's website at [www.ahca.myflorida.org](http://www.ahca.myflorida.org).

## **Responsibilities of All Providers**

The following is a summary of responsibilities specific to all providers who render services to WellCare members. These are intended to supplement the terms of the Agreement, not replace them. In the event of a conflict between this Provider Manual and the Agreement, the Agreement shall govern.

### **Provider Identifiers**

All participating providers are required to have a unique Florida Medicaid provider number and a National Provider Identifier (NPI). For more information on NPI requirements, refer to *Section III. Claims*.

### **Living Will and Advance Directive**

Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Living will and advance directive rights may differ between states.

Each WellCare member (age eighteen (18) years or older and of sound mind), should receive information regarding living will and advance directives. This allows them to designate another person to make a decision should they become mentally or physically unable to do so. WellCare provides information on advance directives in the Member Handbook.

Information regarding living will and advance directives should be made available in provider offices and discussed with the members. Completed forms should be documented and filed in members' medical records.

A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

### **Provider Billing and Address Changes**

Prior notice to your Provider Relations representative or Provider Services is required for any of the following changes:

- 1099 mailing address;
- Tax Identification Number (Tax ID or TIN) or Entity Affiliation (W-9 required);
- Group name or affiliation;
- Physical or billing address; and
- Telephone and fax number.

### **Provider Termination**

In addition to the provider termination information included in the Agreement, you must adhere to the following terms:

- Any contracted provider must give at least ninety (90) days prior written notice (one hundred eighty (180) days for a hospital) to WellCare before terminating your relationship with WellCare "without cause," unless otherwise agreed to in writing. This ensures that adequate notice may be given to WellCare members regarding your participation status with WellCare. Please refer to your Agreement for the details regarding the specific required days for providing termination notice, as you may be required by contract to give more notice than listed above;
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month; and

- Members in active treatment may continue care when such care is medically necessary, through the completion of treatment of a condition for which the member was receiving at the time of the termination or until the member selects another treating provider, not to exceed six (6) months after the provider termination.

Please refer to *Section IV. Credentialing* of this manual for specific guidelines regarding rights to appeal plan termination (if any).

**Note:** WellCare will notify in writing all appropriate agencies and/or members prior to the termination effective date of a participating Primary Care Physician (PCP), hospital, specialist or significant ancillary provider within the service area as required by Florida Medicaid program requirements and/or regulations and statutes.

### **Out-of-Area Member Transfers**

Providers should assist WellCare in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by the WellCare provider and the out-of-network attending physician/provider.

### **Members with Special Health Care Needs**

Individuals with Special Health Care Needs (ISHCN) include members with the following conditions:

- Mental retardation or related conditions;
- Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes;
- Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and
- Related populations eligible for SSI.

The following is a summary of responsibilities specific to providers who render services to WellCare members who have been identified with special health care needs:

- Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
- Coordinate treatment plans with members, family and/or specialists caring for members;
- Plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
- Allow members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the members' conditions or needs;
- Coordinate with WellCare, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care services furnished;
- Coordinate services with other third party organizations to prevent duplication of services and share results on identification and assessment of the member's needs; and

- Ensure the member's privacy is protected as appropriate during the coordination process.

For more information on Utilization Management for ISHCN, refer to *Section V. Utilization Management, Case Management and Disease Management*.

**Responsibilities of Primary Care Physicians (PCP)**

The following is a summary of responsibilities specific to PCPs who render services to WellCare members. These are intended to supplement the terms of the Agreement, not replace them.

- Coordinate, monitor and supervise the delivery of primary care services to each member;
- See members for an initial office visit and assessment within the first ninety (90) days of enrollment in WellCare;
- Coordinate, monitor and supervise the delivery of medically necessary primary and preventive care services to each member, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under the age of twenty-one (21);
- Maintain a ratio of members to full-time equivalent (FTE) physicians as follows:
  - One (1) physician FTE per 1,500 Medicaid or Healthy Kids members;
  - One (1) Advanced Registered Nurse Practitioner (ARNP) FTE for every 750 Medicaid or Healthy Kids members above 1,500; and
  - One (1) Physician Assistant (PA) FTE for every 750 Medicaid or Healthy Kids members above 1,500.
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infant and Children (WIC) program for nutritional assistance;
- Provide or arrange for coverage of services, consultation or approval for referrals twenty-four (24) hours per day, seven (7) days per week. To ensure accessibility and availability, PCPs must provide one of the following:
  - A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
  - Answering system with option to page the physician for a return call within a maximum of thirty (30) minutes; or
  - An advice nurse with access to the PCP or on-call physician within a maximum of thirty (30) minutes.
- The PCP must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the member's needs;
- WellCare shall monitor providers against these standards to ensure members can obtain needed health services within the acceptable appointments and in-office waiting times and after-hours. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare;

PCP - Urgent	< 24 hours
PCP –Sick	< 1 week
PCP – Routine Well Care	< 7 calendar days
PCP – Routine Physical Exams	< 4 weeks
Specialist – Routine	< 30 days

- Assure members are aware of the availability of public transportation where available;

- Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
- Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Healthcare Effectiveness Data and Information Set) service;
- Submit encounters. For more information on encounters, refer to *Section III. Claims*;
- Ensure members utilize network providers. If unable to locate a participating WellCare Medicaid provider for services required, contact Health Services for assistance. Refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides); and
- Comply with and participate in corrective action and performance improvement plan(s).

### **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**

Any provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services are responsible for:

- Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible members in accordance with the Agency's approved Medicaid administrative regulation Sect III C.9.b and the periodicity schedule provided by the American Academy of Pediatrics (AAP);
- Referring the member to an out-of-network provider for treatment if the service is not available within WellCare's network;
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines;
- Providing vaccinations in conjunction with EPSDT/Well Child visits. Providers are required to use vaccines available without charge under the Vaccine for Children (VFC) program for Medicaid children eighteen (18) years old and younger;
- Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits;
- Requesting a prior authorization for a medically necessary EPSDT special services in the event other health care, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Florida Medicaid Program;
- Monitoring, tracking and following up with members:
  - Who have not had a health assessment screening; and
  - Who miss appointments to assist them in obtaining an appointment.
- Ensuring members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with members to ensure they receive the necessary medical services; and
- Assisting members with transition to other appropriate care for children who age-out of EPSDT services.

Providers will be sent a monthly membership list which specifies the health assessment eligible children who have not had an encounter within one-hundred twenty (120) days of joining WellCare or are not in compliance with the EPSDT Program.

Provider compliance with member monitoring, tracking and follow-up will be assessed through random medical record review audits conducted by the WellCare Quality Improvement Department and corrective action plans will be required for providers who are below eighty percent (80%) compliance with all elements of the review.

For more information on EPSDT Covered Services, refer to *Section I. Overview*. For more information on the Florida Medicaid EPSDT periodicity schedule and/or the Florida Medicaid administrative regulation Section III C.9.b, refer to the Agency's website at [www.ahca.myflorida.org](http://www.ahca.myflorida.org). For more information on the periodicity schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at [www.aap.org/healthtopics/immunizations.cfm](http://www.aap.org/healthtopics/immunizations.cfm).

### **Primary Care Offices**

PCPs provide comprehensive primary care services to WellCare members. Primary care offices participating in WellCare's provider network have access to the following services:

- Support of the Provider Relations, Provider Services, Health Services and Marketing and Sales departments; as well as the tools and resources available on WellCare's website at [www.wellcare.com/Provider](http://www.wellcare.com/Provider); and
- Information on WellCare network providers for the purposes of referral management and discharge planning.

### **Closing of Physician Panel**

When requesting closure of your panel to new and/or transferring WellCare members, PCPs must:

- Submit the request in writing at least sixty (60) days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel;
- Maintain the panel to all WellCare members who were provided services before the closing of the panel; and
- Submit written notice of the re-opening of the panel, including a specific effective date.

### **Covering Physicians/Providers**

In the event that participating providers are temporarily unavailable to provide care or referral services to WellCare members, providers should make arrangements with another WellCare-contracted Medicaid (participating) and credentialed provider to provide services on their behalf, unless there is an emergency.

Covering physicians should be credentialed by WellCare, and are required to sign an agreement accepting the negotiated rate and agreeing to not balance bill WellCare members. For additional information, please refer to *Section IV. Credentialing*.

In non-emergency cases, should you have a covering physician/provider who is not contracted and credentialed with WellCare, contact WellCare for approval. For more information, refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

### **Termination of a Member**

A WellCare provider may not seek or request to terminate his/her relationship with a member, or transfer a member to another provider of care, based upon the member's

medical condition, amount or variety of care required or the cost of covered services required by WellCare's member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The provider should provide adequate documentation in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the WellCare member until such time that written notification is received from WellCare stating that the member has been transferred from the provider's practice, and such transfer has occurred.

In the event that a participating provider desires to terminate his/her relationship with a WellCare member, the provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory provider and member relationship, the member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively.

The provider should complete a *Request for Transfer of Member Form*, attach supporting documentation and fax the form to WellCare's Customer Service. A copy of the form is available on WellCare's website at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources) under Forms and Documents.

### **Domestic Violence and Substance Abuse Screening**

PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are located on WellCare's website at [www.wellcare.com/Provider/CCGs](http://www.wellcare.com/Provider/CCGs).

### **Smoking Cessation**

PCPs should direct members who smoke and wish to quit smoking to call WellCare's Customer Service and ask to be directed to the Case Management department. A case manager will educate the member on national and community resources that offer assistance, as well as smoking cessation options available to the member through WellCare.

### **Adult Health Screening**

An adult health screening should be performed by a physician to assess the health status of all WellCare Medicaid members. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

## **Member Administrative Guidelines**

### **Overview**

WellCare will make information available to members on the role of the PCP, how to obtain care, what members should do in an emergency or urgent medical situation as well as members' rights and responsibilities. WellCare will convey this information through various methods including a Member Handbook.

### **Member Handbook**

All newly enrolled members will receive a Member Handbook within five (5) calendar days of receiving the notice of enrollment from WellCare. WellCare will mail all enrolled members a Member Handbook.

## **Enrollment**

WellCare must obey laws that protect from discrimination or unfair treatment. WellCare does not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin.

Upon enrollment in WellCare, members are provided with the following:

- Terms and conditions of enrollment;
- Description of covered services in-network and out-of-network (if applicable);
- Information about PCPs, such as location, telephone number and office hours;
- Information regarding Out-of-Network emergency services;
- Grievance and disenrollment procedures; and
- Brochures describing certain benefits not traditionally covered by Medicaid and other value-added items or services, if applicable.

## **Member Identification Cards**

Member identification cards are intended to identify WellCare members, the type of plan they have and to facilitate their interactions with health care providers. Information found on the member identification card may include the member's name, identification number, plan type, PCP's name and telephone number, co-payment information, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

## **Eligibility Verification**

A member's eligibility status can change at any time. Therefore, all providers should consider requesting and copying a member's identification card, along with additional proof of identification such as a photo ID, and file them in the patient's medical record.

Providers may do one of the following to verify eligibility:

- Access the secure, online Provider Portal of the WellCare website at [www.wellcare.com](http://www.wellcare.com);
- Access WellCare's Interactive Voice Response (IVR) system; and/or
- Contact Provider Services.

You will need your Provider ID number to access member eligibility through the avenues listed above. Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See your Agreement for additional details.

## **Member Rights and Responsibilities**

WellCare members, both adults and children, have specific Rights and Responsibilities. These are included in the Member Handbook.

WellCare members have the right to:

- Be treated with respect and with due consideration for their dignity and privacy;
- Receive information about the plan, its services, its PCPs and health care providers and member rights and responsibilities;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;

- Participate in decisions regarding their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Request and receive a copy of their medical records, and request that they be amended or corrected;
- Be furnished health care services in accordance with federal and state regulations;
- Exercise his or her rights and that the exercise of those rights does not adversely affect the way WellCare and its providers or the Agency treats the member;
- Receive details about what WellCare covers and how to use its services and plan providers;
- Have their privacy protected;
- Know the names and titles of doctors and others who treat them;
- Talk openly about care needed for their health, no matter the cost or benefit coverage;
- Talk openly about care options and risks involved. To have this information shared in a way they understand;
- Know what to do for their health after they leave the hospital or office;
- Refuse to take part in research;
- Receive a proper reply to their complaints;
- Complain about WellCare or the care provided by its network of providers, and to know that if they do, it will not affect how they are treated;
- Create an advance directive;
- Suggest ways WellCare can improve;
- Appeal health care decisions using the proper steps;
- Have a say in WellCare's member rights and responsibilities policy;
- Have all these rights apply to the person who can legally make health care decisions for the member;
- Have all WellCare staff members observe their rights; and
- Use these rights no matter what their sex, age, race, ethnic, economic, educational or religious background.

WellCare members also have certain responsibilities. These include the responsibility to:

- Know how WellCare works by reading the Member Handbook;
- Carry their WellCare card and Medicaid Gold Card with them at all times, and to present them prior to receiving health care services;
- Receive non-emergency care from a primary doctor, to get referrals for specialty care, and to work with those providing care;
- Be on time for appointments;
- Cancel or set a new time for appointments ahead of time;
- Report unexpected changes to their provider;
- Respect providers, staff and other patients;
- Help set treatment goals that they agree to with their provider;
- Follow the treatment plan they agree with their provider;
- Understand medical advice and to ask questions if they do not;
- Know about the medicine they take, what it is for, and how to take it;
- Provide information needed to treat them;
- Ensure their provider has previous medical records; and

- Inform WellCare within forty-eight (48) hours, or as soon as they can, if they are in a hospital or go to an emergency room.

### **Assignment of Primary Care Physician**

Members enrolled in a WellCare Medicaid plan must choose a PCP or they will be assigned to a PCP within WellCare's network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services.

### **Changing Primary Care Physicians**

Members may change their PCP selection at any time by calling Customer Service. The requested change will be effective the first day of the following month of the request if the request is received after the tenth (10<sup>th</sup>) day of the current month.

### **Women's Health Specialists**

PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health specialist for covered services related to this type of routine and preventive care.

### **Hearing- Impaired, Interpreter and Sign Language Services**

Hearing-impaired, interpreter and sign language services are available to WellCare members through WellCare's Customer Service. PCPs should coordinate these services for WellCare members and contact Customer Service if assistance is needed. Please refer to the Quick Reference Guide for the Provider Services telephone numbers which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

## III. Claims

### **Overview**

The focus of WellCare's Claims department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for providers to access a representative in our Customer Service department. For more information, refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

### **Timely Claims Submission**

Unless otherwise stated in the Provider Participation Agreement (Agreement), provider must submit claims (initial, corrected and voided) within six (6) months from the Medicaid or primary insurance payment date, whichever is later) from the date of service for outpatient services and the date of discharge for inpatient services (Hospital Services Manual Section IX Transmittal #17 page 9.3). Unless prohibited by federal law or CMS, WellCare may deny payment for any claims that fail to meet WellCare's submission requirements for Clean Claims or that are received after the time limit in the Agreement for filing Clean Claims.

The following items can be accepted as proof that a claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by WellCare; and
- A provider's electronic submission sheet with all the following identifiers, including patient name, provider name, date of service to match Explanation of Benefits (EOB)/claim(s) in question, prior submission bill dates; and WellCare product name or line of business.

The following items are not acceptable as evidence of timely submission:

- Strategic National Implementation Process (SNIP) Rejection Letter; and
- A copy of the Provider's billing screen.

### **Tax Identification (TIN) and National Provider Identifier (NPI) Requirements**

WellCare requires the payer-issued Tax Identification (Tax ID / TIN) and NPI on all claims submissions. WellCare will reject claims without the Tax ID and/or NPI. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available on the Centers for Medicare and Medicaid Services (CMS) website at [www.cms.hhs.gov](http://www.cms.hhs.gov). More information on Tax ID is available on WellCare's website at [www.wellcare.com/claims/default](http://www.wellcare.com/claims/default).

### **Taxonomy**

Providers must submit claims with the correct taxonomy code consistent with Provider Demographic Information for the Covered Services being rendered in order to be reimbursed at the appropriate rate. WellCare may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

### **Preauthorization number**

If a preauthorization number was obtained, providers must include this number in the appropriate data field on the claim.

### **National Drug Codes (NDC)**

WellCare follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

### **Strategic National Implementation Process (SNIP)**

All claims and encounter transactions submitted via paper, Direct Data Entry (DDE) or electronically will be validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines.

If a claim is rejected for lack of compliance with WellCare's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information on Encounters see page 20.

### **Claims Submission Requirements**

Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI, Tax ID and the valid Taxonomy code that most accurately describes the services reported on the claim. Provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim. Provider also acknowledges and agrees that at no time shall members be responsible for any payments to the provider with the exception of member expenses and/or non-covered services. For more information on paper submission of claims, refer to the Quick Reference Guide which may be found on WellCare's website at

[www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides). For more information on Covered Services under WellCare's Florida Medicaid plans, refer to WellCare's website at [www.wellcare.com/medicaid/our\\_plans](http://www.wellcare.com/medicaid/our_plans). For more information on claims submission requirements, refer to Florida Statute 641.3154.

### **Electronic Claims Submissions**

WellCare accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to WellCare must be in the ANSI ASC X12N format, version 5010. For more information on EDI implementation with WellCare, refer to the Wellcare Companion Guides which may be found on WellCare's website at [www.wellcare.com/Provider/ClaimsUpdates](http://www.wellcare.com/Provider/ClaimsUpdates).

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouse(s), for information on the unique WellCare Payer Identification (Payer ID) numbers used to identify WellCare on electronic claims submissions, or to contact WellCare's EDI team, refer to the *Provider Resource Guide* and/or *Provider How-To Guide*, which may be found on WellCare's website at [www.wellcare.com/Provider/job\\_aids](http://www.wellcare.com/Provider/job_aids).

### **HIPAA Electronic Transactions and Code Sets**

*HIPAA Electronic Transactions and Code Sets* is a federal mandate that requires health care payers such as WellCare, as well as providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA designated content and format.

Specific WellCare requirements for claims and encounter transactions, code sets and SNIP validation are described as follows: *To promote consistency and efficiency for all claims and encounter submissions to WellCare, it is WellCare's policy that these requirements also apply to all paper and DDE transactions.*

For more information on EDI implementation with WellCare, refer to the Wellcare Companion Guides which may be found on WellCare's website at [www.wellcare.com/Provider/ClaimsUpdates](http://www.wellcare.com/Provider/ClaimsUpdates).

### **Paper Claims Submissions**

For more timely processing of claims, providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties in the Agreement. For assistance in creating an EDI process, contact WellCare's EDI team by referring to the Quick Reference Guides which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides). If permitted under the Agreement and until the provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:

- Paper claims must only be submitted on original (red ink on white paper) claim forms.
- Any missing, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for claims submission:
  - **The information must be aligned within the data fields and must be:**
    - Typed;
    - In black ink;
    - Large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type; and
    - In capital letters.
  - **The typed information must not have:**
    - Broken characters;
    - Script, italics or stylized font;
    - Red ink;
    - Mini font; or
    - Dot matrix font.

### **Claims Processing** **Readmission**

WellCare may choose to review claims if data analysis deems it appropriate. WellCare may review hospital admissions on a specific member if it appears that two (2) or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the provider) WellCare will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records, or who do not remit the overpayment amount identified by WellCare, may be subject to a recoupment.

### **48-Hour Rule**

WellCare follows the CMS guidelines for Outpatient Services Treated as Inpatient Services (including but not necessarily limited to: Outpatient Services Followed by Admission Before Midnight of the Following Day, Preadmission Diagnostic Services, and Other Preadmission Services). Please refer to the CMS Claims Processing Manual for

additional information or the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at [http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL\\_05\\_050601\\_Hospital\\_Services\\_ver1.0.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_05_050601_Hospital_Services_ver1.0.pdf).

### **Disclosure of Coding Edits**

WellCare uses claims editing software programs to assist in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and regulations. These software programs may result in claim edits for specific procedure code combinations. These claims editing software programs may result in an adjustment of the payment to the provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to WellCare. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

### **Prompt Payment**

Refer to your Agreement and/refer to Florida Statute 641.3155.

### **Coordination of Benefits (COB)**

WellCare shall coordinate payment for Covered Services in accordance with the terms of a member's benefit plan, applicable state and federal laws and CMS guidance. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan as well as a copy of the Explanation of Benefits (EOB). WellCare may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow WellCare policies and procedures regarding subrogation activity.

### **Encounters Data**

#### **Overview**

This section is intended to provide delegated vendors and providers (IPAs) with the necessary information to allow them to submit encounter data to WellCare. If encounter data does not meet the Service Level Agreements (SLA) for timeliness of submission, completeness or accuracy, the Agency has the ability to impose significant financial sanctions on WellCare. WellCare requires all delegated vendors and delegated providers to submit encounter data, even if they are reimbursed through a capitated arrangement.

#### **Timely and Complete Encounters Submission**

Unless otherwise stated in the Agreement, vendors and providers should submit complete and accurate encounter files to WellCare as follows:

- Encounters submission will be weekly
- Capitated entities will submit within ten (10) calendar days of service date

- Non-capitated entities will submit within ten (10) calendar days of the paid date

The above apply to both corrected claims (error correction encounters) and cap-priced encounters.

### **Accurate Encounters Submission**

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 5 shall be maintained. Once WellCare receives a delegated vendor's or provider's encounters, the encounters are loaded into WellCare's Encounters System and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on WEDI SNIP Edits, refer to their Transaction Compliance and Certification white paper at [www.wedi.org/snip/public/articles/Testing\\_whitepaper082602.pdf](http://www.wedi.org/snip/public/articles/Testing_whitepaper082602.pdf). For more information on submitting encounters electronically, refer to the WellCare Companion Guides which may be found on WellCare's website at [www.wellcare.com/Provider/ClaimsUpdates](http://www.wellcare.com/Provider/ClaimsUpdates).

Vendors are required to comply with any additional encounters validations as defined by the State and/or CMS.

### **Encounters Submission Methods**

Delegated vendors and providers may submit encounters using several methods: electronically, through WellCare's contracted clearinghouse(s), via Direct Data Entry (DDE) or using WellCare's Secure File Transfer Protocol (SFTP) and process.

#### **Submitting Encounters Using WellCare's SFTP Process (*Preferred Method*)**

WellCare accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using WellCare's SFTP process. Refer to WellCare's ANSI ASC X12 837I, 837P and, 837D Health Care Claim / Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. For more information on EDI implementation with WellCare, refer to WellCare's website at [www.wellcare.com/Provider/ClaimsUpdates](http://www.wellcare.com/Provider/ClaimsUpdates).

#### **Submitting Encounters Using Direct Data Entry (DDE)**

Delegated vendors and providers may submit their encounter information directly to WellCare using WellCare's Direct Data Entry (DDE) portal. The DDE tool can be found on the secure, online Provider Portal at [www.wellcare.com/provider/default](http://www.wellcare.com/provider/default). For more information on free DDE options, refer to the Florida Medicaid *Provider Resource Guide* and/or *Provider How-To Guide*, which may be found on WellCare's website at [www.wellcare.com/Provider/job\\_aids](http://www.wellcare.com/Provider/job_aids).

### **Encounters Data Types**

There are four (4) encounter types for which delegated vendors and providers are required to submit encounter records to WellCare. Encounter records should be submitted using the HIPAA standard transactions for the appropriate service type. The four (4) encounter types are:

- Dental - 837D format

- Professional - 837P format
- Institutional - 837I format
- Pharmacy – NCPDP format

This document is intended to be used in conjunction with WellCare's ANSI ASC X12 837I, 837P and, 837D Health Care Claim / Encounter Institutional, Professional and, Dental Guides.

Encounters submitted to WellCare from a delegated vendor or provider can be a new, voided or a replaced / overlaid encounter. The definitions of the types of encounters are as follows:

- New Encounter - an encounter that has never been submitted to WellCare previously.
- Voided Encounter - an encounter that WellCare deletes from the encounter file and is not submitted to the state.
- Replaced or Overlaid Encounter - an encounter that is updated or corrected within the WellCare system.

### **Balance Billing**

Providers shall accept payment from WellCare for Covered Services provided to WellCare members in accordance with the reimbursement terms outlined in the Agreement. Payment made to providers constitutes payment in full by WellCare for covered benefits, with the exception of member expenses. For Covered Services, providers shall not balance bill members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of WellCare's claims policies and/or procedures does not indicate that the service provided is a non-covered service, and members are to be held harmless for covered services. For more information on balance billing, refer to the Florida Statutes 641.3154 and 641.3155 (5)a.(8).

### **Hold Harmless Dual Eligibles**

Those dual eligible members whose Medicare Part A and B member expenses are identified and paid for at the amounts provided for by Florida Medicaid shall not be billed for such Medicare Part A and B member expenses, regardless of whether the amount a provider receives is less than the allowed Medicare amount or provider charges are reduced due to limitations on additional reimbursement provided by Florida Medicaid. Providers shall accept WellCare's payment as payment in full or will bill Florida Medicaid if WellCare has not assumed the Agency's financial responsibility under an agreement between WellCare and the Agency. For more information on holding harmless dual eligible members, refer to the Florida Medicaid Provider General Manual, Chapter 4, located at

[http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH\\_09\\_090204\\_Provider\\_General\\_Hdbk\\_ver1.3.pdf.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf).

### **Claims Appeals**

The claims appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to WellCare in writing within ninety (90) calendar days of the date of denial of the Explanation of Payment (EOP).

Documentation consists of: (a) Date(s) of service; (b) Member name; (c) Member WellCare ID number and/or date of birth; (d) Provider name; (e) Provider Tax ID/TIN; (f) Total billed charges; (g) the Provider's statement explaining the reason for the dispute;

and (h) Supporting documentation when necessary (e.g. proof of timely filing, medical records).

To initiate the process, please mail to the address, or fax to the fax number, listed in your Quick Reference Guide located on WellCare’s website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

**Corrected Claims or Voided Claims**

Corrected and/or Voided Claims are subject to Timely Claims Submission (i.e., Timely Filing) guidelines.

To submit a Corrected or Voided Claim electronically:

- For Institutional claims, provider must include the original WellCare claim number for the claim adjusting or voiding in the REF\*F8 (loop and segment) for any 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.
- For Professional claims, provider must have the Frequency Code marked appropriately as 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.

These codes are not intended for use for original claim submission or rejected claims.

**To submit a Corrected or Voided Claim via paper:**

- For Institutional claims, provider must include the original WellCare claim number and bill frequency code per industry standards.

Example:

Box 4 – Type of Bill: the third character represents the “Frequency Code”

3a PAT. CNTL. #				4 TYPE OF BILL
b. MED. REC. #				117
5 FED. TAX NO.	6 STATEMENT FROM	COVERS PERIOD THROUGH	7	

Box 64 – Place the Claim number of the Prior Claim in Box 64

64 DOCUMENT CONTROL NUMBER
298370064

- For Professional claims, provider must include the original WellCare claim number and bill frequency code per industry standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7 OR 8	123456789012A33456

Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

The Correction or Void Process involves two transactions:

1. The original claim will be negated – paid or zero payment (zero net amount due to a co-pay, coinsurance or deductible) – and noted “*Payment lost/voided/missed.*” This process will deduct the payment for this claim, or zero net amount if applicable.
2. The corrected or voided claim will be processed with the newly submitted information and noted “*Adjusted per corrected bill.*” This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

The Payment Reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

### **Reimbursement**

WellCare applies the CMS site-of-service payment differentials in its fee schedules for Current Procedural Terminology (CPT) codes based on the place of treatment (physician office services versus other places of treatment).

### **Surgical Payments**

Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. The following claims payment policies apply to surgical services:

- **Incidental Surgeries/ Complications** - A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a WellCare Medical Director on whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination** - One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follo w-up Surgery Charges** - Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.

### **Multiple Procedures**

Payment for multiple procedures is based on:

- One-hundred percent (100%) of maximum allowable fee for primary surgical procedure;
- Fifty percent (50%) of maximum allowable fee for secondary surgical procedure; and
- Twenty-five percent (25%) of maximum allowable fee for all other surgical procedures.

The percentages apply when eligible multiple surgical procedures are performed under one (1) continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

For more information, refer to the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at

[http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL\\_10\\_1\\_01103\\_Physician\\_Svcs\\_Hndbk.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_10_1_01103_Physician_Svcs_Hndbk.pdf).

### **Assistant Surgeon**

Assistant Surgeons (AS) are reimbursed sixteen percent (16%) of the maximum allowable fee for the procedure code. Multiple surgical procedures for AS are reimbursed as follows:

- Sixteen percent (16%) of one-hundred percent (100%) of the maximum allowable fee for primary surgical procedure (first claim line);
- Sixteen percent (16%) of fifty percent (50%) of the maximum allowable fee for the second surgical procedure; and
- Sixteen percent (16%) of twenty-five percent (25%) of the maximum allowable fee for all other surgical procedures.

WellCare uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an Assistant Surgeon. For procedures that the ACS lists as “sometimes”, CMS is used as the secondary source.

For more information, refer to the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at

[http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL\\_10\\_1\\_01103\\_Physician\\_Svcs\\_Hndbk.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_10_1_01103_Physician_Svcs_Hndbk.pdf).

### **Co-Surgeon**

Each provider will be paid sixty percent (60%) of the maximum allowable fee for the procedure code. In these cases, each surgeon should report his/her distinct operative work, by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier ‘62’ added.

For more information, refer to the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at

[http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL\\_10\\_1\\_01103\\_Physician\\_Svcs\\_Hndbk.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_10_1_01103_Physician_Svcs_Hndbk.pdf).

### **Modifier**

Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code’s fee or cause a claim to pend for review. The pricing modifiers are 22, 24, 25, 26, 50, 51, 52, 54, 55, 56, 59, 62, 66, 76, 77, 78, 79, 80, and 99, LT/RT, QK, QS, and TC.

For more information, refer to the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at

[http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL\\_10\\_1\\_01103\\_Physician\\_Svcs\\_Hndbk.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_10_1_01103_Physician_Svcs_Hndbk.pdf).

### **Allied Health Providers**

If there are no reimbursement guidelines on the Florida Medicaid website specific to payment for non-physician practitioners or Allied Health Professionals, WellCare follows CMS reimbursement guidelines regarding Allied Health Professionals.

### **Overpayment Recovery**

WellCare strives for one-hundred percent (100%) payment quality but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as retroactive member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s) and other reasons.

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will limit its recovery effort to thirty (30) months from the date of service. However, since November 1, 2008, WellCare limits its recovery effort to twelve (12) months from the date of service for professional claims (CMS-1500) and thirty (30) months from the date of service for institutional claims (UB-04), with the exception for retrospective disenrollment, where institutional claims are also limited to twelve (12) months from the date of service. These time frames do not apply to fraudulent or abusive billing and there is no deadline for WellCare to seek recovery from the provider. In all cases, WellCare, or its designee, will provide a written notice to the provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the member. The notice will also provide the carrier address WellCare has on file but recognizes that the provider may use the carrier address it has on file. The standard request notification provides forty-five (45) days for the provider to send in the refund or contact WellCare, or its designee, for further information or to dispute the overpayment.

Failure of the provider to respond within the above timeframes will constitute acceptance of the terms in the letter and will result in offsets to future payments. Once the overpaid balance has been satisfied, an EOP will be issued. In situations where future billing is not enough to offset the entire overpaid amount, an EOP will not be sent identifying the negative balance. Instead, the provider will need to contact its Provider Relations representative for account information. In situations where the overpaid balance has aged more than three (3) months, the provider may be contacted by WellCare, or its designee, to arrange payment.

If the provider independently identifies an overpayment, it can either (a) send a corrected claim (refer to the corrected claim section of the manual); (b) send a refund and explanation of the overpayment to:

WellCare Health Plans, Inc.  
Recovery Department  
PO Box 31584  
Tampa, FL 33631-3584

or (c) contact Provider Services to arrange an off-set against future payments. For more information on contacting Provider Services, refer to the Quick Reference Guide which may be found on the WellCare website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

### **Benefits During Disaster and Catastrophic Events**

Refer to your Agreement.

## IV. Credentialing

### Overview

Credentialing is the process by which the appropriate WellCare peer review bodies of WellCare evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. For purposes of this Credentialing section, all references to “practitioners” shall include providers providing health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations

This review includes (as applicable to practitioner type):

- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner’s ability to provide health care; and
- Accreditation status, as applicable to non-individuals.

d. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106);  
Practitioners are required to be credentialed prior to being listed as participating network providers of care or services to WellCare members.

The Credentialing department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:

Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank.

Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to WellCare members.

Satisfactory site inspection evaluations are required to be performed in accordance with state, federal, state and accreditation requirements.

After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the provider.

Credentialing may be done directly by WellCare or by an entity approved by WellCare for delegated credentialing. In the event that credentialing is delegated to an outside agency, agency shall be required to meet WellCare's criteria to ensure that the credentialing capabilities of the delegated entity clearly meet, federal and state accreditation (as applicable) and WellCare requirements. The delegated entity's contract must first be approved by AHCA, prior to implementation.

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures, credentialing forms and files.

### **Practitioner Rights**

Practitioner Rights are listed below and included in the application/re-application cover letter.

#### **Practitioner's Right to Be Informed of Credentialing/Re-Credentialing Application Status**

Written requests for information may be e-mailed to [credentialing@wellcare.com](mailto:credentialing@wellcare.com). Upon receipt of a written request, WellCare will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within fifteen (15) business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.

#### **Practitioner's Right to Review Information Submitted in Support of Credentialing/Re-Credentialing Application**

The practitioner may review documentation submitted by him/her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, State licensing agencies and certification boards, subject to any WellCare restrictions. WellCare, or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for provider network participation or re-credentialing.

The provider may not review peer review information obtained by WellCare.

#### **Right to Correct Erroneous Information and Receive Notification of the process and Timeframe**

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by WellCare, the practitioner has the right to review the information that was submitted in support of his/her application, and has the right to correct the erroneous information. WellCare will provide written notification to the practitioner of the discrepant information.

WellCare's written notification to the practitioner includes:

- The nature of the discrepant information;

- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;
- The addressee in Credentialing to whom corrections must be sent;
- WellCare's documentation process for receiving the correction information from the provider; and
- WellCare's review process.

### **Baseline Criteria**

Baseline criteria for practitioners to qualify for provider network participation:

**License to Practice** – Practitioners must have a current, valid, unrestricted license to practice.

**Drug Enforcement Administration Certificate** – Practitioners must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current CDS or CSR certificate (applicable for MD/DO/DPM/DDS/DMD)

**Work History** – Practitioners must provide a minimum of five (5) years' relevant work history as a health professional.

**Board Certification** – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a provider for WellCare or must have verifiable educational/training from an accredited training program in the specialty requested

**Hospital-Admitting Privileges** – Specialist practitioners shall have hospital-admitting privileges at a WellCare-participating hospital (as applicable to specialty). PCP's may have hospital-admitting privileges or may enter into a formal agreement with another WellCare-participating provider who has admitting privileges at a WellCare-participating hospital for the admission of members.

**Ability to Participate in Medicaid and Medicare** – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare Company Plan. Providers are not eligible for participation if such provider owes money to the Medicaid Program or if the Office of the Attorney General has an active fraud investigation involving the provider. Existing providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with WellCare policy and procedure.

**New Providers**– A provider is required to have a Florida Medicaid provider number as well as a National Provider Identifier (NPI) to participate in WellCare's network.

**Providers that Opt-Out of Medicare** – A provider who opts-out of Medicare is not eligible to become a participating provider. An existing provider who opts-out of Medicare is not eligible to remain as a participating provider for WellCare. At the time of initial credentialing, WellCare reviews the state-specific opt-out listing maintained on the designated State Carrier's website to determine whether a provider has opted out of Medicare. Ongoing/quarterly monitoring of the opt-out website is performed by WellCare.

### **Liability Insurance**

WellCare Plan providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits as indicated below, unless otherwise agreed by WellCare in writing.

FL \$250,000/\$750,000 per provider

Providers must furnish copies of current professional liability insurance certificate to WellCare, concurrent with expiration.

### **Site Inspection Evaluation (SIE)**

Site Inspection Evaluations (SIE's) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety and accessibility, performance standards and thresholds were established for:

- Office-site criteria
  - Physical accessibility;
  - Physical appearance; and
  - Adequacy of waiting room and examination room space.
- Medical / treatment record keeping criteria.  
Evidence that the Health Plan has determined that the following documents are
- posted in the provider's waiting room/reception area

SIE's are conducted for:

- Unaccredited Facilities;
- State-specific initial credentialing requirements;
- State-specific re-credentialing requirements; and
- When complaint is received relative to office site criteria.

In those states where initial SIE's are not a requirement for credentialing, there is ongoing monitoring of member complaints. SIE's are conducted for those sites where a complaint is received relative to office site criteria listed above. SIE's may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

### **Covering Physicians**

Primary care physicians in solo practice must have a covering physician who also participates with or is credentialed with WellCare.

### **Attestation to Active Patient Load**

Attestation that the total active patient load (all populations with Medicaid FFS, Children's Medical Services Network, HMO, PSN, Medicare and commercial coverage) is no more than 3,000 patients per PCP. An active patient is one that is seen by the provider a minimum of three (3) times per year;

### **Allied Health Professionals**

Allied Health Professionals (AHP's), both dependent and independent, are credentialed by WellCare.

Dependent AHP's include the following, and are required to provide collaborative practice information to WellCare :

- Advanced Registered Nurse Registered Nurse Practitioners (ARNP);

- Certified Nurse Midwife (CNM);
- Physician Assistant (PA); and
- Osteopathic Assistant (OA).

Independent AHPs include, but are not limited to the following:

- Licensed clinical social worker;
- Licensed mental health counselor;
- Licensed marriage and family therapist;
- Physical therapist;
- Occupational therapist;
- Audiologist; and
- Speech/language therapist/pathologist.

### **Ancillary Health Care Delivery Organizations**

Ancillary and organizational applicants must complete an application and, as applicable, undergo a SIE if unaccredited. WellCare is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage, prior to accepting the applicant as a WellCare provider.

### **Re-Credentialing**

In accordance with regulatory, accreditation and WellCare policy and procedure, re-credentialing is required at least once every three (3) years.

### **Updated Documentation**

In accordance with contractual requirements, providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to provider type) to WellCare, prior to or concurrent with expiration.

### **Office of Inspector General Medicare/Medicaid Sanctions Report**

On a regular and ongoing basis, WellCare or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against the network of providers. If providers are identified as being currently sanctioned, such providers are subject to immediate termination and notification of termination of contract, in accordance with WellCare policies and procedures.

### **Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials**

On a regular and ongoing basis, WellCare or its designee contacts state licensure agencies to obtain the most current available information on sanctioned providers. This information is cross-checked against the network of WellCare providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and WellCare policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to

whether the provider should continue participation or whether termination should be initiated.

### **Participating Provider Appeal through the Dispute Resolution Peer Review Process**

WellCare may immediately suspend, pending investigation, the participation status of a participating provider who, in the opinion of the Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members. In such instances, the Medical Director investigates on an expedited basis.

WellCare has a Participating Provider Dispute Resolution Peer Review Panel process in the event WellCare chooses to alter the conditions of participation of a provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review process has two (2) levels. All disputes in connection with the actions listed below are referred to as a first level Peer Review Panel consisting of at least three (3) qualified individuals of whom at least one (1) is a participating provider and a clinical peer of the practitioner that filed the dispute.

The practitioner also has the right to consideration by a second level Peer Review Panel consisting of at least three (3) qualified individuals of which at least one (1) is a participating provider and a clinical peer of the practitioner that filed the dispute and the second level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by WellCare entitle the practitioner affected thereby to the Provider Dispute Resolution Peer Review Panel Process:

- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service;
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service; or
- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct; service or excessive claims and/or sanction history.

Notification of the adverse recommendation, together with reasons for the action, and the practitioner's rights and process for obtaining the first and or second level Dispute Resolution Peer Review Panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight recorded or certified return-receipt mail.

The practitioner has a period of up to thirty (30) days in which to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review Panel process.

Upon timely receipt of the request, the Medical Director or his/her designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing. WellCare then notifies the practitioner of the schedule for the Review Panel hearing.

The practitioner and WellCare are entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason

for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there from, are arbitrary, unreasonable or capricious.

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five (5) business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first level Panel hearing. In the event the findings are positive for the practitioner, the second level review shall be waived.

In the event the findings of the first level Panel hearing are adverse to the practitioner, the practitioner may access the second level Peer Review Panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first level Peer Review Panel.

Within ten (10) calendar days of the request for a second level Peer Review Panel hearing, the Medical Director or his/her designee shall notify the practitioner of the date, time and access number for the second level Peer Review Panel hearing.

The second level Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five (5) business days after final adjournment of the second level Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the second level Panel hearing via certified or overnight recorded delivery mail. In the event the findings of the second level Peer Review Panel result in an adverse determination for the practitioner, the findings of the second level Peer Review Panel shall be final.

A practitioner who fails to request the Provider Dispute Resolution Peer Review Process within the time and in the manner specified waives any right to such review to which s/he might otherwise have been entitled. WellCare may proceed to implement the termination and make the appropriate report to the National Practitioner Data Bank and State Licensing Agency as appropriate and if applicable.

### **Delegated Entities**

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to *Section XIII. Delegated Entities* section in this provider manual for further details.

# V. Utilization Management (UM), Case Management (CM) and Disease Management (DM)

## Utilization Management

### Overview

WellCare's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the Agency while providing members access to high quality, cost effective medically necessary care. For purposes of this section, terms and definitions may be contained within this section, within the *Section XIV. Definitions* of this manual, or both.

The focus of the UM program is on:

- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member's diagnosis and level of care required;
- Providing access to medically appropriate, cost effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among providers;
- Reducing overall expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership;
- Facilitating communication and partnerships among members, families, providers, delegated entities and the plan in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical health care services.

### Medically Necessary Services

The determination of whether a covered benefit or service is medically necessary complies with the requirements established in Florida Administrative Code, Chapter 59G-1.010. To be medically necessary or a medical necessity, a covered benefit shall:

(a) Meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

In accordance with 42 CFR 440.230, each medically necessary service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

WellCare's UM program includes components of prior authorization, prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on WellCare members' coverage, and the appropriateness of such care and services, and to determine the extent of coverage and payment to providers of care.

WellCare does not reward its associates or any practitioners, physicians or other individuals or entities performing UM activities for issuing denials of coverage, services or care. WellCare does not provide financial incentives to encourage or promote under-utilization.

### **Criteria for UM Decisions**

WellCare's UM program uses nationally recognized review criteria based on sound scientific, medical evidence. Physicians with an unrestricted license in the state of Florida and professional knowledge and/or clinical expertise in the related health care specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- InterQual™
- WellCare Clinical Coverage Guidelines
- Medical necessity
- State Medicaid Contract
- State Provider Handbooks, as appropriate
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment

The nurse reviewer and/or Medical Director involved in the UM process apply medical necessity criteria in context with the member's individual circumstance and the capacity of the local provider delivery system. When the above criteria do not address the individual member's needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.

The review criteria and guidelines are available to the providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by

contacting the Utilization Management department via Provider Services. The phone number is listed on the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

### **UM Process**

The UM process is comprehensive and includes the following review processes:

- Notifications;
- Referrals;
- Prior Authorizations;
- Concurrent Review; and/or
- Retrospective Review.

Decision and notification timeframes are determined by either NCQA® requirements, contractual requirements or a combination of both.

WellCare forms for the submission of notifications and authorization requests can be found on WellCare's website at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources) under Forms and Documents.

### **Notification**

Notifications are communications to WellCare with information related to a service rendered to a member or a member's admission to a facility. Notification is required for:

- Prenatal services. This enables WellCare to identify pregnant members for inclusion into the care coordination program for pregnant members. OB providers are required to notify WellCare of pregnancies via fax using the *Prenatal Notification Form* as soon as possible after the initial visit. This process will expedite case management and claims reimbursement; and
- A member's admission to a hospital. This enables WellCare to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone and include member demographics, facility name and admitting diagnosis.

### **Referrals**

For an initial referral, WellCare does not require authorization as a condition of payment. Certain diagnostic tests and procedures considered by WellCare to be routinely part of an office visit may be conducted as part of the initial visit without an authorization.

### **Prior Authorization**

Prior authorization allows for efficient use of Covered Services and ensures that members receive the most appropriate level of care, within the most appropriate setting. Prior authorization may be obtained by the member's PCP, treating specialist or facility.

Reasons for requiring prior authorization may include:

- Review for medical necessity;
- Appropriateness of rendering provider;
- Appropriateness of setting; and/or
- Case and disease management considerations.

Prior Authorization is **required** for elective or non-emergency services as designated by WellCare. Guidelines for prior authorization requirements by service type may be found on WellCare's website at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources) under Forms and Documents or by calling WellCare.

Some prior authorization guidelines to note are:

- The prior authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request but within the same family of services, a revised authorization is not required.
- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.

The attending physician or designee is responsible for obtaining the prior authorization of the elective or non-urgent admission. Refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides) for a list of services requiring prior authorization.

### **Concurrent Review**

Concurrent review activities involve the evaluation of a continued hospital, Long-Term Acute Care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic or onsite chart review and communication with the attending physician, hospital UM, Case Management staff or hospital clinical staff involved in the member's care.

Concurrent review is initiated as soon as WellCare is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner;
- Make certain that established standards of quality care are met;
- Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Complete timely and effective discharge planning; and
- Identify cases appropriate for case management.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the WellCare Medical Director.

To ensure the review is completed timely, providers must submit notification and clinical information on the next business day after the admission, as well as upon request of the WellCare review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

### **Discharge Planning**

Discharge planning begins upon admission and is designed for early identification of medical and/or psycho-social issues that will need post-hospital intervention. The Concurrent Review Nurse works with the attending physician, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the member to the appropriate level

of care. An Inpatient Review Nurse may refer an inpatient member with identified complex discharge needs to Transitional Care Management for in-facility outreach.

### **Transitional Care Management**

The Transitional Care Management department's role is designed to identify and outreach to members in the hospital and/or recently discharged who are at high risk for readmission to the hospital. The program is a two-fold process; it may begin with a pre-discharge screening to identify members with complex discharge needs, and to assist with the development of a safe and effective discharge plan. Post-discharge, the process focus is to support recently discharged members through short-term case management to meet immediate needs that allows the member to remain at home and reduce avoidable readmissions.

The Care Manager's work includes, but is not limited to: (a) screening for member needs; (b) education; (c) care coordination; (d) medication reconciliation; and € referrals to community based services. Timely follow up is critical to quickly identify and alleviate any care gaps or barriers to care.

The goal of the Transitional Care Program is to ensure that complex, high-risk members are discharged with a safe and effective plan in place, to promote members' health and well-being and reduce avoidable readmissions. The Transitional Care Manager will refer members with long-term needs to Case Management or Disease Management.

### **Retrospective Review**

A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews which WellCare may perform:

- Retrospective Review initiated by WellCare
  - WellCare requires periodic documentation including, but not limited to, the medical record (UB and/or itemized bill) to complete an audit of the provider submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to WellCare to support accurate coding and claims submission.
- Retrospective Review initiated by Providers
  - WellCare will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions and taking into account the member's needs at the time of service. WellCare will also identify quality issues, utilization issues and the rationale behind failure to follow WellCare's prior authorization/pre-certification guidelines.

WellCare will give a written notification to the requesting provider and member within thirty (30) calendar days of receipt of a request for a UM determination. If WellCare is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to fourteen (14) calendar days of the post-service request.

The member or provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Utilization Management department via Provider Services. Refer to your state-specific Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

### **Peer-to-Peer Reconsideration of Adverse Determination**

In the event of an adverse determination following a medical necessity review, Peer-to-Peer Reconsideration is offered to the treating physician on the Notice of Action communication. The treating physician is provided a toll-free number to the Medical Director Hotline to request a discussion with the WellCare Medical Director who made the denial determination. Peer-to-Peer Reconsideration is offered within three (3) business days following the receipt of the written review determination notification by the provider.

The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process.

### **Services Requiring No Authorization**

WellCare has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of members including:

- Certain diagnostic tests and procedures are considered by WellCare to routinely be part of an office visit, such as colonoscopies, hysteroscopies and plain film X-rays;
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a CLIA waiver do not require prior authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
  - Reproductive laboratory tests;
  - Molecular laboratory tests; and
  - Cytogenetic laboratory tests.
- Certain tests described as CLIA-waived may be conducted in the physician's office if the provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to WellCare.

All services performed without prior authorization are subject to retrospective review by WellCare.

### **WellCare Proposed Actions**

A proposed action is an action taken by WellCare to deny a request for services. In the event of a proposed action, WellCare will notify the member and the requesting provider in writing of the proposed action. The notice will contain the following:

- The action WellCare has taken or intends to take;
- The reason(s) for the action;
- The member's right to appeal;
- The member's right to request a state hearing;
- Procedures for exercising member's rights to appeal or file a grievance;
- Circumstances under which expedited resolution is available and how to request it; and
- The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

### **Second Medical Opinion**

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the health care team,

a member, parent(s) and/or guardian(s) or a social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the member by a qualified health care professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

In accordance with Florida statute 641.51, the member may select to have a second opinion provided by a non-contracted provider located in the same geographical service area of WellCare. WellCare will pay the amount of all charges which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with WellCare, but may require the member to be responsible for up to forty percent (40%) of such amount. WellCare may require that any tests deemed necessary by a non-contracted provider be conducted by a participating WellCare provider.

### **Individuals with Special Health Care Needs**

Individuals with Special Health Care Needs (ISHCN) are adults and children/adolescents who face physical, mental or environmental challenges daily that place at risk their health and ability to fully function in society. Factors include: (a) individuals with mental retardation or related conditions; (b) individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; (c) individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and (d) children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to placement in foster care.

Physicians who render services to members who have been identified as having chronic or life threatening conditions should:

- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the member's condition or needs:
  - To obtain a standing authorization the provider should complete the *Outpatient Authorization Request Form* and document the need for a standing authorization request under the pertinent clinical summary area of the form.
  - The authorization request should outline the plan of care including the frequency, total number of visits and the expected duration of care.
- Coordinate with WellCare to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; and
- Ensure that members requiring specialized medical care over a prolonged period of time have access to a specialty care provider.
  - Members will have access to a specialty care provider through standing authorization requests, if appropriate.

## Service Authorization Decisions

Decision timeframes		
	Decision	Extension
Standard Pre-service	Fourteen (14) calendar Days	Fourteen (14) calendar days
Expedited Pre-service	Seventy-two (72) hours	Forty-eight (48) hours
Urgent Concurrent	Twenty-four (24) hours	Forty-eight (48) hours
Post service	Thirty (30) calendar days	Fourteen (14) calendar days

### **Standard Service Authorization**

WellCare will provide a service authorization decision as expeditiously as the member's health condition requires and within state-established timeframe which will not exceed fourteen (14) calendar days. WellCare will fax an authorization response to the provider fax number(s) included on the authorization request form. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the member's best interest.

### **Expedited Service Authorization**

In the event the provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the member's life or health, WellCare will make an expedited authorization determination and provide notice **within seventy-two (72) hours** of the request. An extension may be granted for an additional forty-eight (48) hours if the member or the provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the member's best interest. **Requests for expedited decisions for prior authorization should be requested by telephone**, not fax or WellCare's secure, online Provider Portal. Please refer to the Quick Reference Guide to contact the UM Department via Provider Services, which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

Members and providers may file a verbal request for an expedited decision.

### **Urgent Concurrent Authorization**

An authorization decision for services that are ongoing at the time of the request, and that are considered to be urgent in nature, will be made within twenty-four (24) hours of receipt of the request. An extension may be granted for an additional forty-eight (48) hours.

### **Emergency/Urgent Care and Post-Stabilization Services**

Emergency services are not subject to prior authorization requirements and are available to members twenty-four (24) hours a day, seven (7) days a week. Urgent care services should be provided within one (1) day. See *Section XIII. Definitions* for definitions of "emergency" and "urgent".

Post-Stabilization services are services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve, or resolve the member's condition. Post-Stabilization services are covered

without prior authorization up to the point WellCare is notified that the member's condition has stabilized.

### **Continuity of Care**

WellCare will allow members in active treatment to continue care with a terminated treating provider, when such care is medically necessary, through completion of treatment of a condition for which the member was receiving care at the time of the termination, until the member selects another treating provider, or during the next open enrollment period. None of the above may exceed six (6) months after the termination of the provider's contract.

WellCare will allow pregnant members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider until completion of postpartum care.

For continued care under this provision, WellCare and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

### **Transition of Care**

During the first thirty (30) days of enrollment, authorization is not required for certain members with previously approved services by the state or another managed care plan. WellCare will continue to be responsible for the costs of continuation of such medically necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside WellCare's network until such time as WellCare can reasonably transfer the member to a service and/or network provider without impeding service delivery that might be harmful to the member's health. However, notification to WellCare is necessary to properly document these services and determine any necessary follow-up care.

When relinquishing members, WellCare will cooperate with the receiving health plan regarding the course of on-going care with a specialist or other provider.

When WellCare becomes aware that a covered member will be disenrolled from WellCare and will transition to a Medicaid Fee-For-Service (FFS) program or another managed care plan, a WellCare Review Nurse/Case Manager who is familiar with that member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program.

If a provider receives an adverse claim determination which they believe was a transition of care issue, the provider should fax the adverse claim determination to the Appeals department with documentation of DCH/CMO approval for reconsideration. Refer to the Quick Reference Guide for the Appeals department contact information which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

### **Authorization Request Forms**

WellCare requests providers use our standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to your request, including:

- *Inpatient Authorization Request Form* is used for services such as planned elective/non-urgent inpatient, observation, and skilled nursing facility and rehabilitation authorizations.

- *Outpatient Authorization Request Form* is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, home care services, radiation therapy, out-of-network services and transition of care.
- *Ancillary Authorization Request Form* is used for services such as Durable Medical Equipment (DME), dialysis, Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and transition of care. All Ancillary Authorization Request forms for non-urgent/elective ancillary services should be submitted via fax to the number listed on the form.

To ensure timely and appropriate claims payment, all forms must:

- Have all required fields completed;
- Be typed or printed in black ink for ease of review; and
- Contain a clinical summary or have supporting clinical information attached.

Incomplete forms are not processed and will be returned to the requesting provider. If prior authorization is not granted, all associated claims will not be paid.

A *Prenatal Notification Form* should be completed by the OB/GYN provider during the first visit and faxed to WellCare as soon as possible after the initial visit. Notification of OB services enables WellCare to identify members for inclusion into the Prenatal Program and/or members who might benefit from WellCare's High Risk Pregnancy Program.

All forms are located on WellCare's website at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources) under Forms and Documents. All forms should be submitted via fax to the number listed on the form.

In no instance may the limitations or exclusions imposed by WellCare be more stringent than those specified in the Florida Medicaid Handbooks.

### **Special Requirements for Payment of Services**

The following services have special requirements from the state of Florida:

#### **Abortion**

Prior authorization is required for the administration of an abortion to validate medical necessity per federal regulations. The consent form does not need to be submitted with the request for authorization.

Abortions are covered for eligible WellCare members if the provider certifies that the pregnancy is a result of rape or incest or that the woman is in danger of death unless an abortion is performed.

An *Abortion Certification Form* certifying to the above situation must be properly executed and submitted to WellCare with the provider's claim. This form may be completed and signed by the physician.

Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted.

#### **Sterilizations**

Prior authorization is not required for sterilization procedures. However, WellCare will deny any provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

WellCare will not and is prohibited from making payment for sterilizations performed on any person who:

- Is under twenty-one (21) years of age at the time he/she signs the consent;
- Is not mentally competent; and/or
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.

The required *MAP 250 Consent Form* must be completed and submitted to WellCare.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is thirty (30) calendar days.

The signed consent form expires one-hundred eighty (180) calendar days from the date of the member's signature.

In the case of premature delivery or emergency abdominal surgery performed within thirty (30) calendar days of signed consent, the physician must certify that the sterilization was performed less than thirty (30) calendar days but not less than seventy-two (72) hours after informed consent was obtained. Although these exceptions are provided, the conditions of the waiver will be subject to review.

In the case of premature delivery or emergency abdominal surgery, the sterilization consent form must have been signed by the member thirty (30) calendar days prior to the originally planned date of sterilization. A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to WellCare. The member must sign the consent form at least thirty (30) calendar days, but not more than one-hundred eighty (180) calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

### **Hysterectomy**

Prior authorization is required for the administration of a hysterectomy to validate medical necessity. WellCare reimburses providers for hysterectomy procedures only when the following requirements are met:

- The provider ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the *Hysterectomy Acknowledgement Form*;
- In the case of prior sterility or emergency hysterectomy, a member is not required to sign the consent form; and
- The provider submits the properly executed *Patient's Acknowledgement of Prior Receipt of Hysterectomy Information Form* with the claim prior to submission to WellCare.

WellCare will deny payment on any claim(s) submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

All forms are located on WellCare's website at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources) under Forms and Documents.

### **Delegated Entities**

WellCare delegates some utilization management activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of WellCare and the delegated entities. Agreement must be approved by AHCA prior to implementation.

Delegation of select functions may occur only after an initial audit of the utilization management activities has been completed and there is evidence that WellCare's delegation requirements are met. These requirements include:

- A written description of the specific utilization management delegated activities;
- Semi-annual reporting requirements;
- Evaluation mechanisms; and
- Remedies available to WellCare if the delegated entity does not fulfill its obligations.

On an annual basis, or more frequently as needed, audits of the delegated entity are performed to ensure compliance with WellCare's delegation requirements. For more information on Delegated Entities, refer to *Section XIII. Delegated Entities*.

## **Case Management Program**

### **Overview**

WellCare offers comprehensive integrated Case Management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. WellCare trusts providers will help coordinate the placement and cost-effective treatment of patients who are eligible for WellCare Case Management Programs.

WellCare's multidisciplinary Case Management teams are led by specially trained Registered Nurse (RN) or Licensed Behavioral Health Case Managers who perform a comprehensive assessment of the member's clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan. The Case Managers work collaboratively with

PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

WellCare's Case Management teams also serve in a supportive capacity to the PCP and assists in actively linking the member to providers, medical and behavioral services, residential, social and other support services, as needed. A provider may request case management services for any WellCare member.

The Case Management process illustrates the formation of one seamless Case Management Program and begins with member identification and follows the member until discharge from the Program. Members may be identified for Case Management through numerous ways, including:

- Referral from a member's primary care physician or other specialist;
- Self-referral;
- Referral from a family member;
- Referral after a hospital discharge;
- After completing a Health Risk Assessment (HRA), and
- Data mining for members with high utilization.

WellCare's philosophy is that the Case Management Program is an integral management tool in providing a continuum of care for WellCare members. Key elements of the Case Management process include:

- **Clinical Assessment and Evaluation** – a comprehensive assessment of the member is completed to determine where s/he is in the health continuum. This assessment gauges the member's support systems and resources and seeks to align them with appropriate clinical needs.
- **Care Planning** – collaboration with the member and/or caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the provider's plan of care.
- **Service Facilitation and Coordination** – working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation and follow-up.
- **Member Advocacy** – advocating on behalf of the member within the complex labyrinth of the health care system. Case Managers assist members with seeking the services to optimize their health. Case Management emphasizes continuity of care for members through the coordination of care among physicians, Community Mental Health Centers, and other providers.

Members commonly identified Case Management Program include:

- **Catastrophic** – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns, and multiple traumas;
- **Multiple Chronic Conditions** – multiple co-morbidities such as diabetes, COPD, and hypertension, or multiple intricate barriers to quality health care, i.e., AIDS;
- **Transplantation** – organ failure, donor matching, post-transplant follow-up; and
- **Complex Discharge Needs** – members discharged home from acute inpatient or Skilled Nursing Facility (SNF) with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.; and

- **Special Health Care Needs** – Children or adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental, and developmental disabilities.

## **Disease Management Program**

### **Overview**

Disease management is a population-based strategy that involves consistent care across the continuum for members with certain disease states. Elements of the program include education of the member about the particular disease and self-management techniques, monitoring of the member for adherence to the treatment plan and the consistent use of validated, industry-recognized evidence-based Clinical Practice Guidelines by the treatment team as well as the Disease Manager.

The Disease Management Program targets the following conditions:

- Asthma - adult and pediatric;
- Coronary artery disease (CAD);
- Congestive heart failure (CHF);
- Chronic obstructive pulmonary disease (COPD);
- Diabetes - adult and pediatric;
- HIV/AIDS;
- Hypertension;
- Depression; and
- Smoking Cessation

WellCare's Disease Management Program educates members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The program also focuses on educating the provider with regards to the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of members, improve health outcomes and decrease medical costs. In addition, WellCare makes available to providers and members general information regarding health conditions on WellCare's web site at [www.wellcare.com](http://www.wellcare.com)

### **Candidates for Disease Management**

WellCare encourages referrals from providers, members, hospital discharge planners and others in the health care community.

Interventions for members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized Clinical Practice Guidelines. Members identified at the highest stratification levels receive a comprehensive assessment by a Disease Management nurse, disease-specific educational materials, identification of a care plan and goals and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific Clinical Practice Guidelines adopted by WellCare may be found on WellCare's website at [www.wellcare.com/Provider/CPGs](http://www.wellcare.com/Provider/CPGs).

### **Access to Case and Disease Management Programs**

If you would like to refer a WellCare member as a potential candidate to the Case Management Programs or the Disease Management Program, or would like more

information about one of the programs, you may call the WellCare Case Management Referral Line or complete and fax the *Care Management Referral Form* which can be found on WellCare's website at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources) under Forms and Documents.

For more information on the Case Management Referral Line, refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

# VI. Quality Improvement

## **Overview**

WellCare's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas that include, but are not limited to:

- Quantitative and qualitative improvement in member outcomes;
- Coordination and continuity of care with seamless transitions across health care settings/services;
- Cultural competency;
- Quality of care/service;
- Preventative health;
- Service utilization;
- Complaints/grievances;
- Network adequacy;
- Appropriate service utilization;
- Disease and Case Management;
- Member and provider satisfaction;
- Components of operational service and;
- Regulatory/federal/state/accreditation requirements.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) measures, and/or medical record audits. The organization's Board of Directors has delegated authority to the Quality Improvement Committee to approve specific QI activities, (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective actions plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

## **Medical Records**

Medical records should be comprehensive reflecting all aspects of care for each member. Records are to be maintained in a secure, timely, legible, current, detailed and organized manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Complete medical records include, but are not limited to: medical charts, prescription files, hospital records, provider specialist reports, consultant and other healthcare professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality appropriateness, and timeliness of service provided. Medical records must be signed and dated.

Confidentiality of member information must be maintained at all times. Records are to be stored securely with access granted to authorized-personnel only. Access to records should be granted to WellCare, or its representatives without a fee to the extent permitted by state and federal law. Records remaining under the care, custody, and control of the physician or health care provider shall be maintained for a minimum of ten

(10) years from the date of when the last professional service was provided. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

For more information on medical records compliance, including, but not limited to, Obstetric and Gynecological (OB/GYN) requirements, confidentiality of member information and release of records, refer to *Section IX. Compliance*.

### **Provider Participation in the Quality Improvement Program**

Network providers are contractually required to cooperate with quality improvement activities. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) assessments and feedback/input via satisfaction surveys, grievances, and calls to Customer Service. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Information regarding the QI Program, available upon request, includes a description of the QI Program and a report assessing the progress in meeting goals. WellCare evaluates the effectiveness of the QI Program on an annual basis. An annual report is summarized detailing a review of completed and continuing QI activities that address the quality of clinical care and service, trending of measures to assess performance in quality of clinical care and quality of service, any corrective actions implemented, corrective actions which are recommended or in progress, and any modifications to the program. This report is available as a written document.

### **Member Satisfaction**

On an annual basis, WellCare conducts a member satisfaction survey of a representative sample of members. Satisfaction with services, quality, and access is evaluated. The results are compared to WellCare's performance goals, and improvement action plans are developed to address any areas not meeting the standard.

### **Patient Safety to include Quality of Care (QOC) and Quality of Service (QOS)**

Programs promoting patient safety are a public expectation, a legal and professional standard, and an effective risk-management tool. As an integral component of health care delivery by all inpatient and outpatient providers, WellCare supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues and grievances related to safety.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults and children;
- Prenatal care for pregnant women;
- Well-baby care;
- Immunizations for children, adolescents, and adults; and
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, pap smears, and mammograms.

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the member's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from participating providers and the Quality Improvement Committee. Activities include distribution of information, encouragement to utilize screening tools and ongoing monitoring and measuring of outcomes. While WellCare can and does implement activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.

### **Clinical Practice Guidelines**

WellCare adopts validated evidence-based Clinical Practice Guidelines and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede Clinical Practice Guidelines, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual members and populations. The Clinical Practice Guidelines are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the Clinical Practice Guidelines occurs through the Quality Improvement Committee. Clinical Practice Guidelines, to include Preventative Health guidelines, may be found on the WellCare's website at [www.wellcare.com/Provider/CPGs](http://www.wellcare.com/Provider/CPGs).

### **HEDIS®**

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than ninety percent (90%) of America's health plans to measure performance on important dimensions of care and service. The tool comprises seventy-one (71) measures across eight (8) domains of care, including:

- Effectiveness of care;
- Access and availability of care;
- Satisfaction with the care experience;
- Use of services;
- Cost of care;
- Health plan descriptive information;
- Health plan stability; and
- Informal health care choices.

HEDIS® is a mandatory process that occurs annually. It is an opportunity for WellCare and providers to demonstrate the quality and consistency of care that is available to members. Medical records and claims data are reviewed for capture of required data. Compliance with HEDIS® standards is reported on an annual basis with results available to providers upon request. Through compliance with HEDIS® standards, members benefit from the quality and effectiveness of care received and providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

### **Web Resources**

WellCare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare's website frequently for the latest news and updated documents at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources).

# VII. Appeals and Grievances

## Appeals Process

### Provider

#### **Medicaid Provider on Behalf of Self Appeals Process**

A provider may request an appeal regarding provider payment or contractual issues on his or her own behalf by mailing or faxing a letter of appeal and/or an appeal form with supporting documentation such as medical records to WellCare.

Providers have ninety (90) calendar days from the original utilization management or claim denial to file a provider appeal. Cases appealed after that time will be denied for untimely filing. If the provider feels they have filed their case within the appropriate timeframe, the provider may submit documentation showing proof of timely filing. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of WellCare or similar receipt from other commercial delivery services.

WellCare has thirty (30) calendar days to review the case for medical necessity and conformity to WellCare guidelines.

Cases received without the necessary documentation will be denied for lack of information. It is the responsibility of the provider to provide the requested documentation within sixty (60) calendar days of the denial to re-open the case. Records and documents received after that timeframe will not be reviewed and the case will remain closed.

Medical records and patient information shall be supplied at the request of WellCare or appropriate regulatory agencies when required for appeals. The provider is not allowed to charge WellCare or the member for copies of medical records provided for this purpose.

#### **Reversal of Denial of Provider on Behalf of Self Appeals**

If all of the relevant information is received, WellCare will make a determination within thirty (30) calendar days. If it is determined during the review that the provider has complied with WellCare protocols and that the appealed services were medically necessary, the denial will be overturned. The provider will be notified of this decision in writing.

The provider may file a claim for payment related to the appeal, if they have not already done so. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. WellCare will ensure that claims are processed and comply with the federal and state requirements.

#### **Affirmation of Denial of Provider on Behalf of Self Appeals**

If it is determined during the review that the provider did not comply with WellCare protocols and or medical necessity was not established, the denial will be upheld. The provider will be notified of this decision in writing.

For denials based on medical necessity, the criteria used to make the decision will be provided in the letter. The provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the Appeals address listed in the decision letter.

### **Member**

For a member appeal, the member, member's representative, or a provider acting on behalf of the member and with the member's written consent, may file an appeal request either orally or in writing within thirty (30) calendar days of the date of the adverse organization determination.

If an appeal is filed orally via WellCare's Customer Service, the request must be followed up with a written, signed appeal to WellCare within ten (10) calendar days of the oral filing. For oral filings, the timeframes for resolution begin on the date the oral filing was received by WellCare.

If the member's request for appeal is submitted after thirty (30) calendar days, then good cause must be shown in order for WellCare to accept the late request.

Examples of good cause include, but are not limited to, the following:

- The member did not personally receive the adverse organization determination notice or received the notice late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits; and/or
- The member had incorrect or incomplete information concerning the appeal process.

If the member wishes to use a representative, then s/he must complete an Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on WellCare's website at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources) under Forms and Documents. Members are provided reasonable assistance in completing forms and other procedural steps for an appeal, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD capability.

Providers do not have appeal rights through the member appeals process. However, providers have the ability to file an authorization or claim-related appeal (dispute) on their own behalf. See *Medicaid Provider on Behalf of Self Appeals Process* above for more information.

The member, member's representative or a provider acting on the member's behalf with the member's consent may file for an expedited, standard pre-service or retrospective appeal determination. The request can come from the provider or office staff working on behalf of the provider. Only a provider can request a standard retrospective appeal on his/her own behalf.

WellCare will not take or threaten to take any punitive action against any provider acting on behalf or in support of a member in requesting an appeal or an expedited appeal.

Examples of actions that can be appealed include, but are not limited to, the following:

- Denial or limited authorization of a requested service, including the type or level of service pursuant to 42 CFR 438 400(b);
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for service;
- The failure to provide services in a timely manner, as defined by the Agency;
- The failure of WellCare to act within ninety (90) days from the date WellCare receives a grievance, or thirty (30) calendar days from the date WellCare receives an appeal;
- For a resident of a rural area with only one managed care entity, the denial of a member's request to exercise his or her right to obtain services outside the network.

WellCare ensures that decision-makers on appeals were not involved in previous levels of review or decision-making. When deciding any of the following: (a) an appeal of a denial based on lack of medical necessity; (b) a grievance regarding denial of expedited resolution of an appeal; or (c) a grievance or appeal involving clinical issues. The appeal reviewers will be health care professionals with clinical expertise in treating the member's condition/disease or have sought advice from providers with expertise in the field of medicine related to the request.

WellCare must make a determination from the receipt of the request on a member appeal and notify the appropriate party within the following time frames:

- Expedited Request: **72 hours**
- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **30 calendar days**

The Expedited, Standard Pre-Service and Retrospective Determination periods noted above may be extended by up to fourteen (14) calendar days if the member requests an extension or if WellCare justifies a need for additional information and documents how the extension is in the interest of the member. If an extension is not requested by the member, WellCare will provide the member with written notice of the reason for the delay within two (2) business days of the decision to extend the timeframe.

### **Expedited Appeals Process**

To request an expedited appeal, a member or a provider (regardless of whether the provider is contracted with WellCare) must submit an oral or written request directly to WellCare. A request to expedite an appeal of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision to the member. In light of the short timeframe for deciding expedited appeals, a provider does not need to be an authorized representative to request an expedited appeal on behalf of the member.

Members who orally request an expedited appeal are not required to submit a written appeal request as outlined in the Appeals *Member* section on page 53.

A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited appeal.

### **Denial of an Expedited Request**

WellCare will provide the member with prompt oral notification within twenty-four (24) hours regarding the denial of an expedited appeal and the member's rights, and will

subsequently mail to the member within two (2) calendar days of the oral notification, a written letter that explains:

- That WellCare will automatically transfer and process the request using the thirty (30) calendar day time frame for standard appeals beginning on the date WellCare received the original request;
- The member's right to file an expedited grievance if s/he disagrees with the organization's decision not to expedite the appeal and provide instructions about the expedited grievance process and its time frames; and
- The member's right to resubmit a request for an expedited appeal and that if the member gets any provider's support indicating that applying the standard time frame for making a determination could seriously jeopardize the member's life, health or ability to regain maximum function, the request will be expedited automatically.

### **Resolution of an Expedited Appeal**

Upon an expedited appeal of an adverse determination, WellCare will complete the expedited appeal and give the member (and the provider involved, as appropriate) notice of its decision as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receiving a valid complete request for appeal.

### **Reversal of Denial of an Expedited Appeal**

If WellCare overturns its initial action and/or the denial, it will issue authorization to cover the requested service and notify the member orally within seventy-two (72) hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

### **Affirmation of Denial of an Expedited Appeal**

If WellCare affirms its initial action and/or denial (in whole or in part), it will:

- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Inform the member:
  - Of their right to request a Medicaid Fair Hearing within ninety (90) days and how to do so;
  - Of their right to file a Subscriber Assistance Panel hearing within one (1) year of WellCare's notice of resolution;
  - Of their right to representation;
  - Of their right to continue to receive benefits pending a Medicaid Fair Hearing; and
  - That they may be liable for the cost of any continued benefits if WellCare's action is upheld.

### **Standard Pre-Service Appeals Process**

A member, a member's representative or a provider on behalf of a member with the member's written consent, may file a standard pre-service appeal request either orally or in writing within thirty (30) calendar days of the date of the adverse organization determination.

If an appeal is filed orally through Customer Service, the request must be followed up with a written, signed appeal to WellCare within ten (10) calendar days of the oral filing.

For oral filings, the timeframes for resolution begin on the date the oral filing was received.

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

### **Reversal of Denial of a Standard Pre-Service Appeal**

If, upon standard appeal, WellCare overturns its adverse organization denying a member's request for a service (pre-service request), then WellCare will issue an authorization for the pre-service request.

WellCare will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services. WellCare will also pay for the disputed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

### **Affirmation of Denial of a Standard Pre-Service Appeal**

If WellCare affirms its initial action and/or denial (in whole or in part), it will:

- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the member:
  - Of their right to request a Medicaid Fair Hearing within ninety (90) days and how to do so;
  - Of their right to file a Subscriber Assistance Panel hearing within one (1) year of WellCare's notice of resolution;
  - Of their right to representation;
  - Of their right to continue to receive benefits pending a Medicaid Fair Hearing; and
  - That they may be liable for the cost of any continued benefits if WellCare's action is upheld.

### **Standard Retrospective Appeals Process**

Post-service appeals are typically requests for payment for care or services that the member has already received. Accordingly, a post-service appeal would never result in the need for an expedited review.

A member or a member's representative may file a standard retrospective appeal request either orally or in writing within thirty (30) calendar days of the date of the adverse organization determination. Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

For more information on Appointment of Representative (AOR) statements and oral filings requirements, see Appeals *Member* section on page 53.

### **Reversal of Denial of Standard Retrospective Appeal**

If, upon appeal, WellCare overturns its adverse organization determination denying a member's request for payment, then WellCare will issue its reconsidered determination and send payment for the service.

WellCare will also pay for appealed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

### **Affirmation of Denial of a Standard Retrospective Appeal**

If WellCare affirms its initial action and/or denial (in whole or in part), it will:

- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the member:
  - Of their right to request a Medicaid Fair Hearing within ninety (90) days and how to do so;
  - Of their right to file a Subscriber Assistance Panel hearing within one (1) year of WellCare's notice of resolution;
  - Of their right to representation;
  - Of their right to continue to receive benefits pending a Medicaid Fair Hearing; and
  - That they may be liable for the cost of any continued benefits if WellCare's action is upheld.

### **Medicaid Fair Hearing for Members (Does not apply to Healthy Kids)**

The member has the right to request a Medicaid Fair Hearing, in addition to, and at the same time as, pursuing resolution through WellCare's Grievance and Appeal processes. A provider must have a member's written consent before requesting a Medicaid Fair Hearing on behalf of a member. The parties to a Medicaid Fair Hearing include WellCare, as well as the member, his/her representative or the representative of a deceased member's estate and the State. .

### **Subscriber Assistance Program (SAP)**

Members are notified in the Adverse Determination letter, Member Handbook, and Appeal Decision letter of their right to request a hearing before the SAP. The member must complete WellCare's entire appeals process available before filing a hearing request with the SAP.

A member may submit a request for review of their action and appeal to the SAP. In order for the member to qualify for review, the following criteria must be met:

- The submission of the appeal to the SAP must be done within one (1) year of the date of the occurrence that initiated the appeal;
- If it concerns:
  - The availability of health care services or the coverage of benefits, or an adverse determination about benefits made pursuant to Utilization Management (UM); or
  - Claims payment, handling, or reimbursement for benefits.
- If the member has taken the appeal to a Medicaid Fair Hearing, the member cannot submit the Appeal to the SAP. **This does not apply to Healthy Kids.**

### **Continuation of Benefits while the Appeal and Medicaid Fair Hearing are Pending**

As used in this section, "timely" means filing on or before the later of the following:

- Within ten (10) business days of WellCare mailing the Notice of Adverse Action; or
- Within ten (10) business days after the intended effective date of WellCare's Proposed Action, whichever is later.

WellCare will continue the member's benefits if: (a) the member, or the member's Authorized Representative files the appeal timely; (b) the appeal involves the termination, suspension or reduction of a previously authorized course of treatment; (c) the services were ordered by an authorized provider; (d) the original period covered by the original authorization has not expired; and (e) the member requests extension of the benefits.

If, at the member's request, WellCare continues or reinstates the member's benefit while the Appeal or Medicaid Fair Hearing is pending, the benefits will be continued until one (1) of the following occurs:

- The member withdraws the appeal or request for the Medicaid Fair Hearing;
- Ten (10) business days pass after WellCare mails the Notice of Adverse Action, unless the member, within ten (10) business days, has requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached;
- A Medicaid Fair Hearing officer issues a hearing decision adverse to the member;
- The time period or service limits of a previously authorized service has been met; or
- If the final resolution of the appeal is adverse to the member (i.e., WellCare's decision was upheld), WellCare may recover from the member the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of the contract.

## **Grievance Process**

### **Provider**

Providers have the right to file a written complaint for issues that are non-claims related no later than forty-five (45) calendar days from the date the provider becomes aware of the issue generating the complaint. Written resolution will be provided by WellCare to the provider within forty-five (45) calendar days from the date the complaint is received by WellCare.

A provider may not file a grievance on behalf of the member without written consent from the member as the member's representative.

WellCare will provide all providers written notice of the provider grievance procedures at the time they enter into contract.

For more information, see the *Grievance Submission* section on page 59.

### **Member**

The member or member's representative acting on the member's behalf may file a grievance. Examples of grievances that can be submitted include, but are not limited to:

- Provider Service including, but not limited to:
  - Rudeness by provider or office staff;
  - Failure to respect the member's rights;
  - Quality of care/services provided;

- Refusal to see member (other than in the case of patient discharge from office); and/or
- Office conditions.
- Services provided by WellCare including, but not limited to:
  - Hold time on telephone;
  - Rudeness of staff;
  - Involuntary disenrollment from WellCare; and/or
  - Unfulfilled requests.
- Access availability including, but not limited to:
  - Difficulty getting an appointment;
  - Wait time in excess of one (1) hour; and/or
  - Handicap accessibility.

A member, member's representative or any provider acting on behalf of the member with written consent may file a standard and/or expedited grievance within one (1) year of the incident or when the member was made aware of the incident.

WellCare will ensure that no punitive action is taken against a provider who, as an authorized representative, files a grievance on behalf of a member, or supports a grievance filed by a member. Documentation regarding the grievance will be made available to the member, if requested.

If the member wishes to use a representative, then s/he must complete an Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on WellCare's website at [www.wellcare.com/Provider/Resources](http://www.wellcare.com/Provider/Resources) under Medicaid Provider Forms and Documents.

### **Grievance Submission**

An oral grievance request can be filed, toll-free, with the WellCare Customer Service Department. An oral request may be followed up with a written request by the member, but the timeframe for resolution begins the date the oral filing is received by WellCare. A written provider grievance shall be mailed directly to WellCare's Grievance Department.

For more information on how to contact the Grievance Department, refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

### **Grievance Resolution**

WellCare will acknowledge the member's standard grievance in writing within ten (10) business days from the date the grievance is received by WellCare. Upon receipt of the resolution, a letter will be mailed to the member: (a) within sixty (60) calendar days from the date the standard grievance is received by WellCare; or (b) within a maximum of ninety (90) calendar days, if the grievance involves the collection of information outside the service area. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent, then one letter shall be sent which includes the acknowledgement and the decision of the grievance.

The acknowledgement letter includes:

- Name and telephone number of the Grievance Coordinator; and
- Request for any additional information, if needed to investigate the issue.

The resolution letter includes:

- The results/findings of the resolution;
- All information considered in the investigation of the grievance;
- The date of the grievance resolution; and
- Member rights on Medicaid Fair Hearing.

**Medicaid Fair Hearing for Members (Does not apply to Florida Healthy Kids)**

If a member is dissatisfied with the grievance decision reached by WellCare, the member may request a Medicaid Fair Hearing within ninety (90) calendar days of receiving the grievance resolution letter.

## VIII. Delegated Entities

### **Overview**

WellCare oversees the provision of services provided by the delegated entity and/or sub-delegate, and is accountable to the federal and state agencies, including the Agency, for the performance of all delegated functions. It is the sole responsibility of WellCare to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and WellCare policies and procedures.

### **Compliance:**

WellCare's compliance responsibilities extend to delegated entities, including, without limitation:

- Compliance Plan;
- HIPAA Privacy and Security;
- Fraud, Waste and Abuse Training;
- Cultural Competency Plan; and
- Disaster Recovery and Business Continuity.

Refer to *Section IX. Compliance* for additional information on compliance requirements.

WellCare ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC and its committee representatives:

- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs;
- Ensure that WellCare has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and WellCare, reporting requirements, and delegated activities in a clear and understandable manner;
- Ensure that the appropriate WellCare associates have properly evaluated the entity's ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity's performance at least annually, including monitoring to ensure quality of care and quality of service is not compromised by financial incentives;
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate;
- Assure the delegated entity is in compliance with the requirement in 42 CFR 438;
- Assure that each delegated subcontract:
  - Identifies the population covered by the delegated subcontract;
  - Specifies the amount, duration and scope of services to be provided by the delegated subcontractor;
  - Specifies the term and the procedures and criteria for termination;
  - Specifies that delegated subcontractors use only Agency participating Medicaid providers in accordance with the Florida Contract;
  - Makes full disclosure of the method and amount of compensation or other consideration to be received from WellCare;
  - Provides for monitoring by WellCare of the quality of services rendered to Members, in accordance with the Florida Contract;

- Provides that the Agency and Department of Health and Human Services (DHHS) may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;
- Provide for inspections of any records pertinent to the Florida Contract by the Agency and DHHS;
- Require that records be maintained for a period not less than five (5) years from the close of the Florida Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by WellCare if the subcontract is continuous);
- Where the delegated subcontractor agrees to provide Covered Services, contain no provision that provides incentives, monetary or otherwise, for the withholding from members of medically necessary Covered Services;
- Contains a prohibition on assignment, or on any further subcontracting, without the prior written consent of the subcontractor;
- Specifies that delegated subcontractor agrees to submit encounter records in the format specified by the Agency so that WellCare can meet the Agency's specifications required by the Florida Contract;
- Incorporates all the provisions of the Florida Contract to the fullest extent applicable to the service or activity delegated pursuant to the delegated subcontract, including without limitation, the obligation to comply with all applicable federal and Agency law and regulations;
- Provides for WellCare to monitor the delegated subcontractor's performance on an ongoing basis, including those with accreditation; the frequency and method of reporting to WellCare, the process by which WellCare evaluates the delegated subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;
- Specifies that a delegated subcontractor with NCQA®, URAC or other national accreditation shall provide WellCare with a copy of its current certificate of accreditation together with a copy of the survey report;
- Provides a process for the delegated subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action;
- Specifies the remedies up to and including, revocation of the delegated subcontract available to WellCare if the delegated subcontractor does not fulfill its obligations; and
- Contains provisions that suspected fraud and abuse be reported to WellCare.

# IX. Compliance

## WellCare Compliance Program

### Overview

WellCare's corporate ethics and compliance program, as may be amended from time to time, includes information regarding WellCare's policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by WellCare, WellCare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All providers, including provider employees and sub-contractors and their employees, are required to comply with WellCare compliance program requirements. WellCare's compliance-related training requirements include, but are not limited to, the following initiatives:

- Corporate Integrity Agreement (CIA) Training
  - Effective April 26, 2011, WellCare's CIA with the Office of the Inspector General (OIG) of the United States Department of Health and Human Services (HHS) requires that WellCare maintain and build upon its existing Compliance Program and corresponding training.
  - Under the CIA, the degree to which individuals must be trained depends on their role and function at WellCare.
- HIPAA Privacy and Security Training
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
  - Training includes, but is not limited to discussion on:
    - Proper uses and Disclosures of Protected Health Information (PHI);
    - Member Rights; and
    - Physical and technical safeguards.
- Fraud, Waste and Abuse (FWA) Training
  - Must include, but not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.);
    - Obligations of the provider including provider employees and provider sub-contractors and their employees to have appropriate policies and procedures to address fraud, waste, and abuse;
    - Process for reporting suspected fraud, waste and abuse;
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
    - Types of fraud, waste and abuse that can occur.
- Cultural Competency Training
  - Develop programs to educate and identify the diverse cultural and linguistic needs of the members providers serve.
- Disaster Recovery and Business Continuity
  - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short term or long term interruption of services.

Providers, including provider employees and/or provider sub-contractors, must report to WellCare any suspected fraud, waste or abuse, misconduct or criminal acts by

WellCare, or any provider, including provider employees and/or provider sub-contractors, or by WellCare members. Reports may be made anonymously through the WellCare fraud hotline at (866) 678-8355.

Details of the corporate ethics and compliance program may be found on WellCare's website at [www.wellcare.com/AboutUs/default](http://www.wellcare.com/AboutUs/default).

### **Provider Education and Outreach**

Providers may:

- Display State-approved health-plan specific materials in-office;
- Announce a new affiliation with a health plan; and
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers and print advertisement.

Providers are prohibited from:

- Orally, or in writing, comparing benefits or providers networks among health plans, other than to confirm their participation in a health plan's network;
- Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity;
- Furnishing health plans' membership lists to the health plan, such as WellCare, or any other entity; and
- Assisting with health plan enrollment.

## **Code of Conduct and Business Ethics**

### **Overview**

WellCare has established a [Code of Conduct and Business Ethics](http://www.wellcare.com/AboutUs/default) that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. WellCare's Code of Conduct and Business Ethics policy can be found at [www.wellcare.com/AboutUs/default](http://www.wellcare.com/AboutUs/default).

The Code of Conduct and Business Ethics (the Code) is the foundation of iCare, WellCare's Corporate Ethics and Compliance Program. It describes WellCare's firm commitment to operate in accordance with the laws and regulations governing our business and accepted standards of business integrity. All providers should familiarize themselves with WellCare's [Code of Conduct and Business Ethics](http://www.wellcare.com/AboutUs/default). Participating providers and other contractors of WellCare are encouraged to report compliance concerns and any suspected or actual misconduct. Report suspicions of Fraud, Waste and Abuse by calling the WellCare FWA Hotline at (866) 678-8355.

### **Fraud, Waste and Abuse (FWA)**

WellCare is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. WellCare has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and WellCare vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that

unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504) providers and their employees must complete an annual FWA training program.

To report suspected fraud and abuse, please refer to your Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides) or call our confidential and toll-free WellCare compliance hotline. Details of the corporate ethics and compliance program, and how to contact the WellCare fraud hotline, may be found on WellCare's website at [www.wellcare.com/AboutUs/default](http://www.wellcare.com/AboutUs/default).

### **Confidentiality of Member Information and Release of Records**

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the HIPAA privacy and security rules and regulations, as may be amended. All provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members' medical records and other Protected Health Information (PHI), and the practice is following those procedures and/or obtaining appropriate authorization from members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every provider practice is required to provide members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Some examples of confidential information include:

- Medical records;
- Communication between a member and a provider regarding the member's medical care and treatment;

- All personal and/or protected health information (PHI) as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
- Any communication with other clinical persons involved in the member's health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc);
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
- Any communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

The NPP informs the member of their rights under HIPAA and how the provider and/or WellCare may use or disclose the members' PHI. HIPAA regulations require each covered entity, such as health care providers, to provide a NPP to each new patient or member.

### **Medical Records**

Member medical records must be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.

The member's medical record is the property of the provider who generates the record. However, each member or their representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available to members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).

Each provider is required to maintain a primary medical record for each member, which contains sufficient medical information from all providers involved in the member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information, on each page;
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;
- Date of data entry and date of encounter;
- Late entries should include date and time of occurrence and date and time of documentation;
- Provider identification by name and profession of the rendering provider (e.g., MD, DO, OD);
- Allergies and/or adverse reactions to drugs shall be noted in a prominent location;
- Past medical history, including serious accidents, operations, illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);

- Identification of current problems;
- The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;
- A current list of immunizations pursuant to 42 CFR 456; Identification and history of nicotine, alcohol use or substance abuse;
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 42 CFR 456;
- Follow-up visits provided secondary to reports of emergency room care;
- Hospital discharge summaries;
- Advanced Medical Directives, for adults;
- Documentation that member has received the provider's office policy regarding office practices compliant to HIPAA;
- Documentation regarding permission to share protected health information with specific individuals has been obtained; and
- Record is legible to at least a peer of the writer and written in standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

A member's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and
- Plan of treatment including:
  - Medication history, current medications prescribed, including the strength, amount, directions for use and refills;
  - Therapies and other prescribed regimen; and
- Follow-up plans including consultation and referrals and directions, including time to return; and Education and instructions whether verbal, written or via telephone

### **OB/GYN Medical Records**

Medical record requirements and guidelines:

- Pre-term delivery risk assessment is rendered by the twenty-eighth (28<sup>th</sup>) week;
- The member will be seen by an obstetrician **within the first (1<sup>st</sup>) trimester** of the pregnancy with the following assessments performed and documented:
  - Weight;
  - Blood Pressure;
  - Fetal heart tones;
  - Hemoglobin and Hematocrit (H&H);
  - Urinalysis;
  - Blood typing and anti-body screening;
  - Rubella anti-body titer;
  - Syphilis screening;
  - HBsAg screening;
  - Pap smear; and
  - Nutrition assessment

- The member will be seen **once every month in the second (2<sup>nd</sup>) trimester** of pregnancy with the following assessments performed and documented:
  - Weight;
  - Blood pressure;
  - Fetal heart tones;
  - Hemoglobin and Hematocrit (H&H);
  - Urinalysis;
  - Alpha-fetoprotein (between fifteen (15) to twenty (20) weeks);
  - Diabetes screening/GTT (between twenty-four (24) to twenty-eight (28) weeks);
  - Repeat anti-body test for un-sensitized RH negative patients (twenty-eight (28) weeks); and
  - Prophylactic administration of Pho(D) immune globulin (twenty-eight (28) weeks), if indicated.
- The member will be seen **twice every month in the third (3<sup>rd</sup>) trimester** of pregnancy and **one (1) visit per week in the ninth (9<sup>th</sup>) month** with the following assessments performed and documented:
  - Weight;
  - Blood pressure;
  - Fetal heart tones;
  - Hemoglobin and Hematocrit (H&H);
  - Urinalysis;
  - Testing for sexually transmitted diseases (STDs) /sexually transmitted infections (STIs) and HBsAg for high-risk members; and
  - Group B strep screening for high-risk members (thirty-five (35) to thirty-seven (37) weeks).

The maternity chart will contain documentation of the following:

- Physical findings on each visit with a plan of treatment and follow-up for any abnormalities;
- Nutritional assessment and counseling for all pregnant members that includes:
  - Promotion of breastfeeding and the use of breast milk substitutes to ensure the provision of safe and adequate nutrition for infants;
  - Offering a mid-level nutrition assessment;
  - Providing individual diet counseling and a nutrition care plan by a public health nutritionist;
  - A nurse or physician following the nutrition assessment; and
  - Ensuring documentation of the nutrition care plan in the medical record by the person providing counseling.
- Member education (childbirth/maternal care);
- Postpartum care – at least one (1) complication-free visit, or appropriate follow-up if complications exist;
- Family planning counseling and services for all pregnant women and mothers;
- HIV testing/counseling is offered at the initial prenatal care visit and again at twenty-eight (28) weeks and thirty-two (32) weeks:
  - The provider will attempt to obtain a signed objection if a pregnant woman declines an HIV test and keeps this signed objection in the medical record; and
  - All HIV infected women are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human services (Public Health Service Task Force Report entitled *Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-a*

*Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 transmission in the United States).*

- Screening for Hepatitis B;
  - Providers must screen all pregnant members during their first prenatal visit for Hepatitis B and again between twenty-eight (28) and thirty-two (32) weeks for members who test negative and are considered high-risk for Hepatitis B; and
  - All HBsAg-positive women shall be reported to the local county health department and to Healthy Start, regardless of their Healthy Start screening score.
- **Healthy Start** – pregnant women will receive a prenatal risk screening as part of their first prenatal visit. Provider will complete the Department of Health (DOH) Prenatal Risk form (DH 3134), retain a copy in the member's medical record, forward a copy within ten (10) business days to the county health department where the screening was performed, and provide a copy to the member. Providers will maintain documentation of Healthy Start screenings, assessments, findings, and referrals in the enrollee's medical record;
- Healthy Start Infant (Postnatal) Screening Instrument (form DH 3135) is to be completed with the certificate of live birth and submitted to the county health department in the county where the child was born within ten (10) business days of the birth. The provider must retain a copy in the member's medical record and provide a copy to the member;
- Pregnant enrollees or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start screen, in the following ways:
  - If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the enrollee or infant is invited to participate based on factors other than score; or
  - If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start care coordinator based on the assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance abuse or domestic violence.
- Providers refer all pregnant, breastfeeding and postpartum women to the local Women, Infants and Children (WIC) office:
  - Providers provide a completed Florida WIC program medical referral form with the current height or length and weight (taken within sixty (60) calendar days of the WIC appointment);
  - Hemoglobin or Hematocrit (H&H);
  - Any identified medical/nutritional problems;
  - Give a copy of the completed form to the member; and
  - Retain a copy of the completed form in the member's medical record.

### **Disclosure of Information**

Periodically, members may inquire as to the operational and financial nature of their health plan. WellCare will provide that information to the member upon request. Members can request the above information verbally or in writing.

For more information on how to request this information, members may contact WellCare's Customer Service using the toll-free telephone number found on the member's ID card. Providers may contact WellCare's Provider Services by referring to the Quick Reference Guides which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

# Cultural Competency Program and Plan

## Overview

The purpose of the Cultural Competency program is to ensure that WellCare meets the unique, diverse needs of all members, to provide that the associates of WellCare value diversity within the organization, and to see that members in need of linguistic services have adequate communication support. In addition, WellCare is committed to having our providers fully recognize and care for the culturally diverse needs of the members they serve.

The objectives of the Cultural Competency program are to:

- Identify members that have potential cultural or linguistic barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken;
- Make resources available to meet the unique language barriers and communication barriers that exist in the population;
- Help providers care for and recognize the culturally diverse needs of the population;
- Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served; and
- Decrease health care disparities in the minority populations we serve.

Culturally and linguistically appropriate services (CLAS) are health care services provided that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent health care and services requires health care providers and/or their staff to possess a set of attitudes, skills, behaviors and policies which enable the organization and staff to work effectively in cross-cultural situations.

The components of WellCare's Cultural Competency program include:

- **Data Analysis**
  - Analysis of claims and encounter data to identify the health care needs of the population; and
  - Collection of member data on race, ethnicity and language spoken.
- **Community-Based Support**
  - Outreach to community-based organizations which support minorities and the disabled in ensuring that the existing resources for members are being utilized to their full potential.
- **Diversity and Language Abilities of Health Plan Staff**
  - Non-Discriminating – WellCare may not discriminate with regard to race, religion or ethnic background when hiring associates;
  - Recruiting – WellCare recruits diverse talented associates in all levels of management; and
  - Multilingual – WellCare recruits bilingual associates for areas that have direct contact with members to meet the needs identified, and encourages providers to do the same.
- **Diversity of Provider Network**
  - Providers are inventoried for their language abilities and this information is made available in the Provider Directory so that members can choose a provider that speaks their primary language; and
  - Providers are recruited to ensure a diverse selection of providers to care for the population served

- **Linguistic Services**
  - Providers will identify members that have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance;
  - Members may receive interpreter services at no cost when necessary to access covered services through a vendor, as arranged by the Customer Service Department;
  - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by WellCare's Customer Service Department; and
  - Written materials are available for members in large print format, and certain non-English languages, prevalent in WellCare's service areas.
- **Electronic Media**
  - Telephone system adaptations - members have access to the TTY/TDD line for hearing impaired services. WellCare's Customer Service department is responsible for any necessary follow-up calls to the member. The toll-free TTY/TDD number can be found on the member identification card.
- **Provider Education**
  - WellCare's Cultural Competency Program provides a Cultural Competency Checklist to assess the provider office's Cultural Competency;
  - For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on WellCare's website at [www.wellcare.com](http://www.wellcare.com). A paper copy, at no charge, may be obtained upon request by Contacting Provider Services or your Provider Relations representative; and
  - Providers must adhere to the Cultural Competency program as set forth above.

### **Cultural Competency Survey**

You may access the Cultural Competency Survey on WellCare's website at [www.wellcare.com/provider/resources](http://www.wellcare.com/provider/resources) under the Provider Training and Education link.

# X. Behavioral Health

## **Overview**

WellCare provides a behavioral health benefit for Medicaid plans. All provisions contained within the Provider Manual are applicable to medical and behavioral health providers unless otherwise noted in this section.

WellCare has designated Magellan Behavioral Health (Magellan) to manage WellCare's behavioral health program. For complete information regarding benefits and exclusions, contact Magellan as referenced in your Quick Reference Guide, which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides). You may also access Magellan's medical necessity criteria and Clinical Practice Guidelines on Magellan's provider website at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider).

## **Behavioral Health Program**

All behavioral health services require prior authorization including those services provided by non-participating providers. In the event the member is in need of a referral to a behavioral health provider, contact Magellan.

## **Continuity and Coordination of Care Between Medical Care and Behavioral Healthcare**

PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if and when they are licensed to do so within the scope of their practice. Behavioral providers are required to use the DSM-IV multi-axial classification when assessing the member for behavioral health services and document the DSM-IV diagnosis and assessment/outcome information in the member's medical record.

Behavioral health providers are required to submit, with the member's or member's legal guardian's consent, an initial and quarterly summary report of the member's behavioral health status to the PCP. Communication with the PCP should occur more frequently if clinically indicated. The Plan encourages behavioral health providers to pay particular attention to communicating with PCP's at the time of discharge from an inpatient hospitalization (the Plan recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP). Please send this communication, with the properly signed consent, to the members identified PCP noting any changes in the treatment plan on the day of discharge.

We strongly encourage open communication between PCPs and behavioral health providers. If a member's medical or behavioral condition changes, WellCare expects that both PCPs and behavioral health providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between providers.

To maintain continuity of care, patient safety and member well-being, communication between behavioral health care providers and medical care providers is critical, especially for members with co-morbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and impact member outcomes.

### **Responsibilities of Behavioral Health Providers**

WellCare monitors providers against these standards to ensure members can obtain needed health services within the acceptable appointments waiting times. The provisions below are applicable only to behavioral health providers and do not replace the provisions set forth in *Section II. Member and Provider Administrative Guidelines* for medical providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

BH Provider – Emergent	< 24 hours
BH Provider – Urgent	< 48 hours
BH Provider – Post Inpatient discharge	< 7 days
BH Provider – Routine	< 10 days
BH Provider – <b>Non-life Threatening Emergency</b>	< 6 hours

All members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place, and name of the provider to be seen. The outpatient treatment must occur within seven (7) days from the date of discharge.

In the event that a member misses an appointment, the behavioral health provider must contact the member within twenty-four (24) hours to reschedule.

Behavioral health providers are expected to assist members in accessing emergent, urgent, and routine behavioral services as expeditiously as the member's condition requires. Members also have access to a toll free behavioral crisis hotline that is staffed twenty-four (24) hours a day. The behavioral crisis phone number is printed on the member's card and is available on our website.

For information about WellCare's Case Management and Disease Management programs, including how to refer a member for these services, please see *Section V: Utilization Management (UM), Case Management (CM) and Disease Management (DM)*.

# XI. Pharmacy

## **Overview**

WellCare's pharmaceutical management procedures are an integral part of the pharmacy program that ensure and promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of our members. The utilization management tools that are used to optimize the pharmacy program include:

- Preferred Drug List (PDL);
- Drug Evaluation Review (DER) Process;
- Mandatory Generic Policy;
- Step Therapy (ST);
- Quantity Level Limit (QL);
- Pharmacy Lock-In Program; and
- Network Improvement Program (NIP).

These processes are described in detail below. In addition, prescriber and member involvement is critical to the success of the pharmacy program. To help your patient get the most out of their pharmacy benefit please consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, i.e., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) VII Hypertension guidelines;
- Prescribe drugs listed on the PDL;
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class; and
- Evaluate medication profiles for appropriateness and duplication of therapy.

To contact WellCare's Pharmacy department, please refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

## **Preferred Drug List**

The PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmaceutical and Therapeutics Committee (P&T Committee). The PDL denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

The P&T Committee's selection of drugs is based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature and cost effectiveness profile. The medications on the PDL are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, age limitation, prior authorization and step therapy).

The PDL can be found on our website at [www.wellcare.com](http://www.wellcare.com). Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to providers at least annually via the following:

- Quarterly updates in provider and member newsletters;
- Website updates; and/or
- Pharmacy and provider communication that detail any major changes to a particular therapy or therapeutic class.

### **Additions to the Preferred Drug List**

To request consideration for addition of a drug to WellCare's PDL, providers may write WellCare explaining the medical justification. For contact information, refer to your Quick Reference Guide at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

For more information on requesting exceptions, refer to the *Drug Evaluation Review Process* on page 77.

### **Generic Medications**

The use of generics represents a key drug management tool. Generic drugs are equally effective and generally less costly than their brand name counterparts. Their use can contribute to cost-effective therapy.

Generic drugs must be dispensed by the pharmacist when available as the therapeutic equivalent to a brand name drug. Exceptions to the mandatory generic policy require medical justification when therapeutic equivalents are available. A DER form should be completed when requiring an exception. Clinical justification as to why the generic alternative is not appropriate for the member should be included with the DER form.

For more information on the DER process, including how to access the DER form, see *Drug Evaluation Review Process* on page 77.

### **Injectable and Infusion Services**

Select self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Most self-injectable products and all infusion drug requests require a DER using the Injectable Infusion Form.

Approved self-injectable and infusion drugs are covered when supplied by contracted retail pharmacies and infusion vendors. Please contact the Pharmacy department regarding criteria related to specific drugs. The specific J-codes of any self-injectable products that do not require authorization when given in a doctor's office are included in the *No Auth Required CPT Codes List*.

Refer to WellCare's website at [www.wellcare.com/Provider](http://www.wellcare.com/Provider) for more information. You may access the *No Auth Required CPT Codes List* under the Pharmacy tab on the Provider page, and access the *Injectable Infusion Form* in the Forms and Documents section on the Provider Resources page.

### **Hemophilia Medications**

**Staywell Health y Kids and Heal thEase He althy Kids covers he mophilia-related medications.** Since September 1, 2006, WellCare is not responsible for covering hemophilia-related medications for HealthEase and Staywell. The member must contact the Agency directly at (850) 487-4441 to receive this benefit from an Agency-approved organization.

### **Coverage Limitations**

WellCare covers all drug categories currently available through the Florida Medicaid fee-for-service program. The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- Agents used for anorexia, weight gain or weight loss;
- Agents used to promote fertility;
- Agents used for cosmetic purposes or hair growth;

- Non-prescriptive, over-the-counter (OTC drugs\*) with a few exceptions listed on the PDL;
- Cough and cold combination medications for members 21 and older;
- Drugs for the treatment of erectile dysfunction;
- DESI drugs or drugs that may have been determined to be identical, similar or related;
- Vitamin or mineral products, including prenatals or fluoride preparations (fluoride not covered over age 12), except for those listed on the PDL;
- Investigational or experimental drugs; and
- Agents prescribed for any indication that is not medically accepted.

WellCare will not reimburse for prescriptions for refills too soon, duplicate therapy or excessively high dosages for the member.

*\*All OTC drugs listed on the PDL as covered will require a prescription for the pharmacy to dispense.*

### **Informed Consent for Psychotropics Medications**

Effective September 1, 2011, and pursuant to statute 409.912(51), the Agency may not pay for a psychotropic medication prescribed for a child in the Medicaid program without the express and informed consent of the child's parent or legal guardian. Providers are required to document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription. For purposes of this manual, and pursuant to Florida statute 394.492(3), "child" means a person from birth until the person's thirteenth (13<sup>th</sup>) birthday.

For the full Agency Health Care Alert and Provider Message, including a list of Psychotropic (Psychotherapeutic) Medications, step-by-step instructions and a variety of consent forms, refer to the Agency's website at [http://ahca.myflorida.com/Medicaid/Prescribed\\_Drug/med\\_resource.shtml](http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml).

### **Step Therapy and Quantity Level Limits:**

Step therapy (ST) programs are developed by the P&T Committee. These programs are designed to encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before "stepping-up" to less cost-effective alternatives. Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven, safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on our PDL have been evaluated through the use of clinical literature and are approved by our P&T Committee.

Quantity limits can be used to ensure that pharmaceuticals are supplied in a quantity consistent with Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits can also be used to help prevent billing errors. Please refer to the PDL to view drugs requiring step therapy and those with quantity level limits.

### **Over-the-Counter (OTC) Medications**

OTC items listed on the PDL require a prescription. Examples of OTC items listed on the PDL include:

- Multivitamins and multiple vitamins with iron (chewable or liquid drops);
- Iron;

- Non-sedation antihistamines;
- Enteric coated aspirin;
- Diphenhydramine;
- Insulin;
- Topical antifungals;
- Ibuprofen suspension;
- Permethrin;
- Meclizine;
- Insulin syringes;
- Urine test strips;
- H-2 receptor antagonists; and
- Proton Pump Inhibitors.

For a complete listing, please refer to the PDL which can be found on our website at [www.wellcare.com/provider](http://www.wellcare.com/provider).

### **Pharmacy Lock-In Program**

Members identified as over-utilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple physicians, or frequently visiting the Emergency Room seeking pain medication will be placed in Pharmacy Lock-in (Lock-in) status for a minimum of one (1) year. While in Lock-in, the member will be restricted to one (1) prescribing physician and one (1) pharmacy to obtain their medications. Claims submitted by other prescribers or other pharmacies will not be paid for the member. Members identified will also be referred to Case Management.

Members in the Lock-in program will be reviewed annually by the P&T Committee who shall determine the need for further lock-in according to established procedures and federal regulations regarding such action.

### **Member Co-Payments**

- \$0 co-payment for HealthEase and Staywell members; and
- \$5 co-payment for HealthEase and Staywell Healthy Kids members.

### **Drug Evaluation Review Process (Requesting Exceptions)**

The goal of the Drug Evaluation Review (DER) program (also known as prior authorization) is to ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications. The DER process is required for:

- Duplication of therapy;
- Prescriptions that exceed the FDA daily or monthly quantity limit;
- Most self-injectable and infusion medications;
- Drugs not listed on the PDL;
- Drugs that have an age edit;
- Drugs listed on the PDL but still require Prior Authorization (PA);
- Brand name drugs when a generic exists; and
- Drugs that have a step edit (ST) and the first-line therapy is inappropriate.

Providers may request an exception to WellCare's PDL orally or in writing. For written requests, providers should complete a *Drug Evaluation Review (DER) Form*, supplying pertinent member medical history and information. A DER form may be accessed on

WellCare's website at [www.wellcare.com/Provider](http://www.wellcare.com/Provider) under the Forms and Documents section.

To submit a request, orally or in writing, refer to the contact information listed on your Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

Upon receipt of the DER, a decision is completed within seventy-two (72) hours for a standard DER request and twenty-four (24) hours for an expedited DER request. If authorization cannot be approved or denied, and the drug is medically necessary, a seven (7) day emergency supply of the non-preferred drug shall be supplied to the member.

Prior Authorization (PA) protocols are developed and reviewed at least annually by the P&T Committee. These protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). The criteria are available upon request when submitted to the Pharmacy department by the member or provider.

### **Medication Appeals**

To request an appeal of a DER request decision, contact the Pharmacy Appeals department via fax, mail, in person or phone. Refer to your Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides).

Once the appeal of the Drug Evaluation Review request decision has been properly submitted and obtained by WellCare, the request will follow the appeals process described in *Section VII. Appeals and Grievances*.

### **Pharmacy Management - Network Improvement Program (NIP)**

The Pharmacy Network Improvement Program (NIP) is designed to provide physicians with quarterly utilization reports to identify over and under-utilization of pharmaceutical products. The reports will also identify opportunities for optimizing best practices guidelines and cost-effective therapeutic options. These reports are delivered by the State Pharmacy Director and/or Clinical Pharmacy Manager to physicians identified for the program.

### **WellCare's Specialty Pharmacy**

WellCare offers Specialty Pharmacy services to members who are taking medications to treat long-term, life-threatening or rare conditions. WellCare's Specialty Pharmacy team are experts in the special handling, storage and administration of these medications (i.e., injectables, infusables, orals) require. This team knows the insurance process and the member's plan benefits. This means less chance of delays in a member receiving their needed medication(s). Prescription orders generally ship directly to the member's home, provider's office, or alternative address provided by the member, within twenty-four (24) to forty-eight (48) hours after contacting WellCare's Specialty Pharmacy representative. The actual ship date depends on whether or not provider discussion is needed about the prescription.

To learn more about the conditions covered under WellCare's Specialty Pharmacy, or how to contact, refer to WellCare's website at [www.wellcare.com/provider/WellCareSpecialtyPharmacy](http://www.wellcare.com/provider/WellCareSpecialtyPharmacy).

## XII. Definitions – Florida Medicaid

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the participation agreement you have with WellCare.

**“Action”** means, pursuant to 42 CFR 438.400(b), the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; or the failure of WellCare to act within ninety (90) days from the date WellCare receives a grievance, or forty-five (45) days from the date WellCare receives an appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.

**“Advance Directive”** means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

**“Agency”** means State of Florida, Agency for Health Care Administration.

**“Appeal”** means a formal request from an enrollee to seek a review of an action taken by WellCare pursuant to 42 CFR 438.400(b).

**“Authorization”** means an approval request for payment of services. An authorization is provided only after WellCare agrees the treatment is necessary.

**“Benefit Plan”** means a schedule of health care services to be delivered or other health covered service contract or coverage document (a) issued by WellCare or (b) administered by WellCare pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

**“Business Days”** means traditional workdays, which are Monday through Friday. Federal and/or state holidays may be excluded.

**“Calendar Days”** means all seven (7) days of the week.

**“Carve-Out Agreement”** means an agreement between WellCare and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve-Out Agreements include agreements for behavioral health, radiology, laboratory, dental, vision, or hearing services.

**“Centers for Medicare and Medicaid Services (CMS)”** means the agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the State Children’s Health Insurance Program under Title XXI of the Social Security Acts.

**“Child Health Check-Up-Program (CHCUP)”** means a set of comprehensive and preventive health examinations provided on a periodic basis to identify and correct medical conditions in children/adolescents. Refer to the “EPSDT” definition for more information.

**“Children/Adolescents”** means members under the age of twenty-one (21). For purposes of the provision of Behavioral Health services, means members under the age of eighteen (18) as defined by the Department of Children and Families (DCF).

**“Clean Claim”** means a claim for Covered Services that a) is received timely by WellCare, b) can be processed without obtaining additional information from the provider of the service or from a third party and, c) is not subject to coordination of benefits or subrogation issues. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity pursuant to 42 CFR 447.45

**“CLIA”** means the federal legislation commonly known as the Clinical Laboratories Improvement Amendments of 1988 as found at Section 353 of the federal Public Health Services Act (42 U.S.C. §§ 201, 263a) and regulations promulgated hereunder.

**“Co-Surgeon”** means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

**“Covered Services”** means Medically Necessary items and services covered under a Benefit Plan.

**“Department of Children and Families (DCF)”** means State of Florida, Department of Children and Families.

**“EPSDT”** means Early and Periodic Screening, Diagnosis and Treatment program that provides medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a), to all members under the age of twenty-one (21).

**“Emergency Medical Condition”** means (a) a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical

attention could result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes (see Section 395.002, F.S.).

**“Emergency Services and Care”** means medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

**“Encounter Data”** means a record of covered services provided to a WellCare member. An “encounter” is an interaction between a patient and provider (WellCare, rendering physician, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient..

**“Grievance”** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or WellCare employee or failure to respect the enrollee's rights.

**“Ineligible Person”** means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

**“LTAC”** means a Long-Term Acute Care hospital.

**“Member”** means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

**“Member Expenses”** means copayments, coinsurance, deductibles or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

**“Members/Individuals with Special Health Care Needs”** means members with special needs are defined as adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

**“Periodicity”** means the frequency with which an individual may be screened or re-screened.

**“Periodicity Schedule”** means the schedule which defines age-appropriate services and timeframes for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program.

**“Primary Care Provider (PCP)”** means a WellCare staff or contracted physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

**“Prior Authorization”** means the act of authorizing specific services before they are rendered.

**“Provider”** means a person or entity eligible to provide Medicaid services and that has a contractual agreement with WellCare to provide services. PSN fee-for-service providers must have an active Medicaid provider agreement. All other providers must be eligible for a Medicaid provider agreement.

**“Referral”** means a request by a PCP for a member to be evaluated and/or treated by a specialty physician.

**“Routine Care”** means the level of care that can be delayed without anticipated deterioration in the member’s condition.

**“Screening”** Assessment of an enrollee’s physical or mental condition to determine evidence or indications of problems and need for further evaluation.

**“Service”** means health care, treatment, a procedure, supply, item or equipment.

**“Service Location”** means any location at which a member may obtain any health care service covered by WellCare under the terms of the Provider Contract.

**“Urgent Care”** means services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or could substantially restrict an enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

**“WellCare Companion Guide”** means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to WellCare or its Affiliates, as amended from time to time. The WellCare Claims/Encounter Companion Guides are part of the Provider Manual.

**“Zero Cost Share Dual Eligible Member”** means a Dual Eligible Member that is not responsible for paying any Part A or Part B cost sharing.

## **XIII. WellCare Resources – Florida Medicaid**

### **Forms and Documents**

[www.wellcare.com/Provider/Resource](http://www.wellcare.com/Provider/Resource) under Medicaid Forms and Documents

### **Quick Reference Quick Reference Guides**

[www.wellcare.com/Provider/QuickReferenceGuides](http://www.wellcare.com/Provider/QuickReferenceGuides)

### **Clinical Practice Guidelines**

[www.wellcare.com/Provider/CPGs](http://www.wellcare.com/Provider/CPGs)

### **Clinical Coverage Guidelines**

[www.wellcare.com/Provider/CCGs](http://www.wellcare.com/Provider/CCGs)

### **Job Aids and Resource Guides**

[www.wellcare.com/Provider/Job\\_Aids](http://www.wellcare.com/Provider/Job_Aids)

### **Provider Orientation**

[www.wellcare.com/Provider/ProviderTraining](http://www.wellcare.com/Provider/ProviderTraining). You must be a registered user of WellCare's secure, online Provider Portal to access.

