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**Overview**

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, *Case management* is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Case management emphasizes continuity of care for the members through the coordination of care among physicians and other providers. Case management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting.

- Primary Care Physicians (PCPs) serve as principal case manager and coordinator of care. The Plan's case management team serves a support capacity to the PCP and assists in coordinating care actively linking member to providers, medical services, residential, social and other support services where needed.
- The case management team is comprised of specially qualified nurses who the case management process assess the member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the treatment plan.
- The Plan has incorporated case management programs that manage members with specific health care needs such as, catastrophic diseases (adult and pediatric), transplant, wounds, HIV and obstetrics. The physician may request case management services for any of the Plan members.
- The Plan has adopted practice guidelines that are based on valid and reliable clinical evidence from the American College of Obstetrical and Gynecology (ACOG) for the OB program. The case management Society of America (CMSA)

standards of care and the Agency for Health Care Research and Quality (AHRQ) for the wound care program.

**Transplant Case Management**

WellCare offers a transplant case management program with a dedicated transplant case manager to ensure that information is available to providers and to facilitate all aspects of the transplantation process. A transplant case manager will be assigned to assist providers in the multiple needs of the member as a transplant candidate.

The transplant case management team will:

1. Evaluate the member for eligibility and covered transplant benefit;
2. Assist providers in initiating transplant protocol;
3. Provide a list of potential facilities for transplantation based on:
  - Medicare Centers of Excellence
  - Geographical proximity to the patient
  - Specific tissue/organ transplantation team availability
  - Testing and preparation for transplant;
4. Act as the member's advocate, emotional support and insurance plan liaison;
5. Request medical documentation and records from the office; and
6. Facilitate approval of transplant benefits.

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**Obstetrical  
Care**

In support of obstetrical care, the Plan has adopted Guidelines of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG). These clinical practice guidelines are based on valid and reliable clinical evidence.

The Plan contracts with participating providers for OB care that includes OB as well as midwife services. The OB or midwife must complete the Prenatal Notification form (found in the **Forms** section of this manual) at the first prenatal visit and fax the completed form to Plan's OB department. Upon receipt, the Plan will give comprehensive authorization for prenatal, delivery and post partum care. Additionally, the member will be enrolled in the Prenatal Program and evaluated for enrollment in the High Risk OB Case Management Program. If a pregnant member is receiving care from a non-participating provider, the Plan will make special arrangements to reimburse the provider for the member's care though the postpartum period.

The provider is required to provide the most appropriate and highest level of quality care for pregnant women. Required care includes the following:

**Authorizations  
for OB Care**

- The OB physician or midwife must complete the Prenatal Notification form (found in the **Forms** section of this manual) at the first prenatal visit and fax the completed form to the Plan's OB department to obtain an authorization for OB care. Ultrasounds or other services performed in a hospital will require an authorization.

**OB Physician  
Functioning  
as the PCP**

The OB physician may function as the PCP during the pregnancy and may request referrals and authorizations for that member during their pregnancy.

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**High-Risk  
OB Case  
Management**

The focused High-Risk OB Case Management Program provides assistance to members that are identified as potential high-risk pregnancies. If the physician notifies the Plan of a member's non-compliance, the high-risk OB case manager can support the physician with necessary interventions to encourage compliance.

The High-Risk Case Management Program:

- Educates members on their medical condition;
- Coordinates care through the continuum; and
- Assists the member in being an active participant in their own health care.

**The Prenatal  
Program**

The Prenatal Program promotes a healthy pregnancy and delivery for the member and baby. The member receives educational material, trimester and post partum letters and a Prenatal Reward form. The member will present the Prenatal Reward Form to the physician for signature at the end of each trimester and at the postpartum visit. The physician completes the form, signs the form at the bottom and faxes it back to the Plan. The member will receive a stroller for keeping at least six prenatal visits and a postpartum visit (between the third and eighth weeks) with their OB.

**Women, Infants  
and Children (WIC)  
Office**

Participating physicians are required to refer all pregnant women, breastfeeding and postpartum women, infants and children/adolescents up to age five to the local Women, Infants and Children (WIC) office.

The physician must:

1. Complete the WIC program Medical Referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment),
  - Hemoglobin or hematocrit; and
  - Any identified medical/nutritional problems.

2. For subsequent WIC certifications, coordinate with the local WIC office to provide the above referral data from the most recent child health check-up (CHCUP).
3. Give a copy of each WIC Referral form to the member and retain a copy in the member's medical record.

**HIV  
Counseling**

Florida state law requires all women of childbearing age be provided HIV counseling and offered HIV testing.

- Participating physicians should offer HIV counseling and HIV testing at the initial prenatal care visit and again at 28 to 32 weeks.
- Participating physicians should attempt to obtain a signed objection if a pregnant woman declines an HIV test.
- Participating physicians should ensure that all pregnant women who are infected with HIV are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services. A copy of the guideline can be obtained by contacting DOH, Bureau of HIV/AIDS at (850) 245-4334, or go to <http://aidsinfo.nih.gov/guidelines/>. Participating physicians will refer all pregnant women who test positive for HIV and their infants to Healthy Start regardless of their Healthy Start screening score.

**Hepatitis B  
Screening**

Participating physicians should screen all pregnant women receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit.

- Participating physicians should perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant women who tested negative at the first prenatal visit and are

considered high-risk for Hepatitis B infection. This test should be performed at the same time that other routine prenatal screening is ordered.

- All HBsAg positive women must be reported to the local county health department (CHD) regardless of their Healthy Start screening score.

Infants born to HBsAg-positive women must receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth and will complete the Hepatitis B Maxine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.

- Participating physicians should test infants born to HBsAg-positive members for HBsAb and hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series to monitor the success or failure of the therapy.
- Participating physicians should report to the local CHD a positive HBsAg result in any child 24 months or less within 24 hours of receipt of the positive test result.
- Participating physicians should ensure that infants born HBsAg-positive are referred to Healthy Start regardless of the Healthy Start screening score.

Participating physicians should report all prenatal or postpartum members who test HBsAg-positive to the Perinatal Hepatitis B Prevention Coordinator at the local CHD. The physician should also report these members' infants and contacts to the Perinatal Hepatitis B Prevention Coordinator at the local CHD.

- Participating physicians should report the following information: name, date of birth, race, ethnicity, address, infants, contacts, laboratory

test performed, date sample collected, the due date or EDC, whether or not the member received prenatal care and immunization dates for infants and contacts.

- Participating physicians should use the Perinatal Hepatitis B Case and Contact Report (DH Form 1876) for reporting purposes.

**Lead Level Screening Program**

The Plan provides case management services to all eligible children with blood lead levels (BLL) equal to or greater than 10 mcg/dl. Services include:

- Family education about lead poisoning;
- Assistance in obtaining lead abatement;
- Coordination of testing of siblings;
- Scheduling of appointments; and
- Coordination of transportation, when needed.

Those members with elevated blood lead levels will be identified through a monthly lead level report from contracted laboratories and from the Plan's CHCUP.

**Disease Management Programs**

The Disease Management Program proactively identifies members with asthma and diabetes and provides education for these members and/or their caregivers to empower them to make behavior changes to ensure the choices they make will improve their health and reduce the complications of their disease. In addition, the program educates members and their caregivers, regarding the standards of care for asthma or diabetes, triggers to avoid and to ensure they are receiving the appropriate medications.

The program also focuses on educating the provider with regards to the standards of care for asthma and diabetes and current treatment recommendations. Intervention and education will improve the quality of life of members, improve health outcomes and decrease medical costs.

- Members are stratified according to the severity of their disease.
- All members receive educational mailings and have the opportunity to request additional educational material specific to their condition or needs.
- Members who are stratified in the most high-risk categories receive telephonic intervention by a disease management nurse. The nurse conducts a telephonic disease-specific health risk assessment and provides education regarding the disease process.
- All members also receive periodicity letters to remind them of the preventive health care they need.
- Members receive flu and pneumonia reminders.
- Member newsletters that feature articles related to asthma and diabetes are mailed to members.
- Providers receive Clinical Practice Guidelines based on nationally-recognized evidence-based guidelines.
- Providers also receive Fax Alerts that are designed to alert the physicians to unacceptable lab values and inappropriate medication usage, in addition to hospitalizations and ER visits.
- Providers receive newsletters that feature articles regarding the latest treatment guidelines.

### **Delegated Entities**

WellCare delegates some case 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 that they meet the required case

management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of WellCare and the delegated entities. Delegation of select functions may occur only after an initial audit of the case 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/case management delegated activities;
- Semi-annual reporting requirements and evaluation mechanisms;
- Remedies available to WellCare if the delegated entity does not fulfill its obligations

On an annual basis, or more frequently, audits of the delegated entity are performed to ensure compliance with WellCare's delegation requirements.