

## PROVIDER RESPONSIBILITIES

### Section 2

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#### Overview

This section of the Provider Handbook addresses the respective responsibilities of participating providers.

#### Responsibilities of Primary Care Physicians

Following is a summary of responsibilities specific to Primary Care Physicians (PCPs) who render services to Plan members. Please also refer to the listing of Responsibilities of All Providers. These are intended to supplement the terms of the Provider Agreement.

1. Coordinate, monitor and supervise the delivery of primary care services to each member.
2. Assure the availability of physician services to members in accordance with Appointment Scheduling as outlined in this section.
3. Arrange for on-call and after-hours coverage in accordance with the After-Hours Services as outlined in this section.
4. Assure members are aware of the availability of public transportation where available.
5. Provide access to the Plan 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.
6. Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Health Plan Employer Data and Information Set) service.
7. Submit encounters on a paper CMS 1500 or UB 04 form or its electronic equivalent, as each may be amended from time to time.
8. Ensure members utilize network providers. If unable to locate a participating provider for

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services required, contact Health Services for assistance.

9. See members for an initial office visit and assessment within the first 90 days of enrollment in the Plan. To assist members in receiving such health assessments upon enrollment, the Plan's Quality Improvement department will:
  - Send a periodicity letter to members within 45 days of enrollment, encouraging an appointment with their PCP within 90 days;
  - Conduct annual medical record reviews on a randomly selected set of high-volume PCPs (targeting both initial and continuous health assessments);
  - Develop corrective action and performance improvement plans with the PCP if needed and perform reassessments to ensure compliance of corrective action plans.
10. Comply with and participate in corrective action and performance improvement plan.

### **Primary Care Offices**

Primary Care Physicians (PCPs) provide comprehensive primary care services to Plan members. Primary care offices participating in the Plan provider network have access to the following Plan services:

- Support of the Provider Relations, Customer Service, Provider Service Center, Health Services and Marketing and Sales departments.
- Information on Plan network providers for the purposes of referral management and discharge planning.

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#### **Domestic Violence & Substance Abuse Screening**

PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are located in the **Member and Provider Education Materials** section of this Handbook.

#### **Smoking Cessation**

Physicians influence the decisions members make about their health care. The Plan offers a list of national smoking cessation programs that will help members break both their physical and psychological addiction to cigarettes.

PCPs should direct members who smoke and wish to quit smoking to call 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 the Plan.

More information on smoking cessation is located in the **Member and Provider Education Materials** section of this Handbook.

#### **Adult Health Screening**

An adult health screening should be performed by a physician to assess the health status of all Medicare Advantage members. The adult member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the Adult Preventive Care Guidelines in the **Member and Provider Education Materials** section of this Handbook.

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

*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.

They include members with the following conditions:

- Mental retardation or related conditions;

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

Following is a summary of responsibilities specific to physicians who render services to Plan members who have been identified with special health care needs:

1. Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
2. Coordinate treatment plans with members, family and/or specialists caring for members;
3. Plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
4. 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;
5. Coordinate with the Plan, 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;
6. Coordinate services with other third party organizations to prevent duplication of services and share results on identification and

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assessment of the member's needs; and

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

#### **After-Hours Services**

The PCP must be available after regular office hours to offer advice and to assess any condition that may require immediate care. This includes referral to the nearest hospital emergency room in the event of a serious illness.

To ensure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service;
- Answering system with option to page the physician; or
- An advice nurse with access to the PCP or on-call physician.

#### **Closing of Physician Panel**

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

- Submit the request in writing at least 90 days (or such other period of time provided in their Provider Agreement) prior to the effective date of closing his or her panel;
- Maintain his or her panel to all Plan members who were provided services before the closing of his or her panel; and
- Submit written notice of the re-opening of his or her panel, including a specific effective date.

#### **Vacations**

PCPs should notify the Plan in writing of any vacation time scheduled and information regarding the provisions that have been made for coverage in the PCPs absence. The provider covering for the PCP

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must be a credentialed provider with our Plan.

#### **Responsibilities of All Providers**

The remainder of this section is an overview of responsibilities for which all Plan providers are accountable. Please refer to your Provider Agreement or contact your Provider Relations representative for clarification of any of the following.

Physicians must, in accordance with generally accepted professional standards:

1. 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 state and Plan guidelines.
2. Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
3. Clearly identify their titles (examples: MDs, DOs, ARNPs, PAs) to members and to other health care professionals.
4. Honor at all times any member request to be seen by a physician rather than a physician extender.
5. Administer treatment for any member in need of health care services they provide.
6. Refer Plan members with problems outside of his or her normal scope of practice for consultation and/or care to appropriate specialists contracted with the Plan.
7. Refer members to participating physicians or providers, except when they are not available or in the case of an emergency.

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8. Admit members only to participating hospitals, skilled nursing facilities (SNFs) and other inpatient care facilities, except in an emergency or when unusual circumstances require specialized care rendered in non-participating facilities.
9. Respond promptly to Plan requests for medical records in order to comply with regulatory requirements.
10. Inform Plan in writing within 24 hours of any revocation or suspension of his/her DEA number and/or suspension, limitation or revocation of his or her license, certification or other legal credential authorizing him or her to practice in any state.
11. Consistent with the Plan's credentialing and re-credentialing policies, immediately inform the Plan, in writing, of changes to license status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his/her status with the Plan.
12. Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Plan member, subscriber or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a fee-for-service basis. Non-covered services are services not covered in the member's Plan contract.
13. Inform members proactively of non-covered services and obtain members' written acknowledgement that they have been informed.
14. Keep all member records and information confidentially in compliance with state and

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federal laws and regulations.

15. Maintain accurate medical records and adhere to all Plan policies governing the content of medical records as outlined in the quality improvement guidelines as set forth in the **Medical Records** section of this Handbook.
16. Maintain valid Clinical Laboratory Improvement Amendment(s) (CLIA) certificate(s), if applicable.
17. Prepare, maintain and retain complete and accurate medical, fiscal and administrative records regarding covered services rendered to Medicare Advantage members consistent with the terms of the Provider Agreement.
18. Continue to provide covered services to Medicare Advantage members after the expiration or termination of their Provider Agreement, as provided therein.
19. Agree to comply with all applicable state and federal laws, rules and regulations governing the Medicare Advantage Program, The Centers for Medicare & Medicaid Services (CMS) instructions and applicable requirements of the Medicare contract.
20. Represent and warrant that: (a) all employed physicians and other health care practitioners and providers shall comply with the terms and conditions of their Provider Agreement; (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 Provider 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 Provider

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Agreement.

21. Follow all CMS and Plan requirements and understand the Plan remains accountable and responsible to CMS for compliance with the terms and conditions of its contract with CMS (the “Medicare contract”), regardless of the provisions of the Agreement or any delegation of administrative activities or functions under the Provider Agreement.
22. Provide the Plan and/or CMS with timely access to records, information and data necessary for: (1) the Plan to meet its obligations under its Medicare contract(s); and/or (2) CMS to administer and evaluate the Medicare Advantage program; and to submit all reports and clinical information required by the Plan under the Medicare contract.
23. Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.
24. Communicate timely clinical information between Plan providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to the Plan, the member or the requesting party at no charge, unless otherwise agreed.
25. 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.
26. Not discriminate in any manner between Plan members and non-Plan members.
27. Fully disclose to members their treatment

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options and allow them to be involved in treatment planning.

28. Inform members of specific health care needs that require follow-up care and provide, as appropriate, training in self-care and other measures members may take to promote their own health.
29. Encourage members to utilize the nurse help line (Plan's telephone-based triage program available in certain markets) for free-telephonic, medical advice 24 hours a day, 7 days a week. Please refer to your state-specific **Quick Reference Guide** for the telephone number for the Plan's nurse help line.
30. 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 Plan-sponsored or community-based programs.
31. Must document the referral to Plan-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.

### **Specialist Responsibilities**

Specialists are responsible for treating Plan members referred to them by the PCP and communicating with the Plan's Health Services department for authorizations. Specialists may not refer to another Plan specialist. Referrals for Medicare Advantage members must be coordinated through members' PCPs.

A PCP referral is not required for access to network behavioral health specialists. Behavioral health specialists are responsible for communicating

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treatment, admissions, discharges and prescribing practices to the PCP.

#### **Covered Out-of-Network Services in Non-Emergency Situations**

In non-emergency cases, POS and PPO benefit plan options cover certain services by non-participating providers at a lower benefit level. This means the member's cost share is higher than if they receive covered services from a participating provider. Members' ID cards will list the type of benefit plan to which they belong.

#### **HMO**

There is no out-of-network option offered with this plan except in the event of an emergency. Members must be referred to participating physicians or providers, except when they are not available. Contact the Health Services department for assistance.

#### **HMO with POS**

Before referring members to a non-participating provider for services, contact Health Services for assistance determining whether the services will be covered at the in-network or out-of-network benefit level. Out-of-network services may be covered at the in-network benefit level if, for example, a participating provider for the required services cannot be located. The referring physician should advise members whether to expect to pay their in-network (co-pay) or out-of-network (coinsurance) cost share for the covered services.

#### **PPO Plans**

PPO plans do not require referrals or authorizations for covered out-of-network services. Out-of-network services may be covered at the in-network benefit level if, for example, a participating provider for the required services is not available.

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

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

#### **Request for Transfer of a Member**

A Plan physician or provider may not seek or request to terminate his or 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 the Plan's member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The physician or 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 or physician shall continue to provide medical care for the Plan member until such time that written notification is received from the Plan stating that the member has been transferred from the provider's or physician's practice, and such transfer has occurred.

In the event that a participating physician or provider desires to terminate his/her relationship with a Plan member, the physician or 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 physician or provider should complete a Request for Transfer of Member form, attach supporting documentation and fax the form to Customer Service. A copy of the form is available in the **Forms** section of this Handbook.

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**Confidentiality of  
Member  
Information &  
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 of the Health Insurance Portability and Accountability Act of 1996, as may be amended (HIPAA). All physician 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 as defined under HIPAA); 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 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 physician regarding the member's medical care and treatment;
- All personal and/or protected health information as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;

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- 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;
- 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 Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or the Plan may use or disclose the members' PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or member.

### **Member Rights & Responsibilities**

Plan members have specific Rights and Responsibilities which physicians should post in their offices for all members to see. Contact a Provider Relations representative for copies of the Patient Rights and Responsibilities as needed.

Refer to the **Member Services** section for more information on member rights and responsibilities.

### **Living Will & 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.

Each Plan member (age 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.

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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.

### Appointment Scheduling

Providers must adhere to the following criteria to comply with state and/or federal availability and access standards:

1. Primary Care Providers must:
  - Provide medical coverage 24 hours a day, seven days a week;
  - See scheduled appointments within 30 minutes of the appointment time;
  - Schedule and see emergent referral appointments immediately;
  - Schedule and see urgent appointments within one day;
  - Schedule and see non-urgent, but in need of attention appointments within one week;
  - Schedule and see routine and preventive care appointments within one month.
2. Specialty Care Providers must:
  - Schedule and see emergent referral appointments immediately;
  - Schedule and see urgent referral appointments within one day;
  - Schedule and see non-urgent, but in need of attention appointments within one week;

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- Schedule and see routine and preventive care appointments within one month

#### **Covering Physicians**

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

Covering physicians should be credentialed by the Plan, must sign an agreement accepting the negotiated rate and agreeing not to balance bill Plan members. For additional information, please contact Provider Relations.

In non-emergency cases, should you have a covering physician who is not contracted and credentialed with the Plan, contact the Plan for approval.

#### **Provider Billing & Address Changes**

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

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

#### **Provider Termination**

In addition to the provider termination information included in your Provider Agreement with the Plan, the provider must adhere to the following terms:

- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.

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- Please refer to the **Credentialing** section of this Handbook for specific guidelines regarding rights to administrative review plan termination (if any).

**Note:** The Plan will notify in writing all appropriate agencies and/or members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary provider within the service area as required by Medicare Advantage program requirements and/or regulations and statutes.

#### **Marketing & Sales**

Providers should contact the Plan's Marketing & Sales department to discuss and coordinate permissible provider involvement in Plan marketing activities.

All marketing materials (including any type of advertising such as billboards, flyers, ads, TV, radio, etc.) describing or mentioning the Plan, affiliation or utilizing the Plan's name or logo must be approved by the Plan prior to any use or distribution. All materials must adhere to the Medicare guidelines and approval from the Plan and CMS, as appropriate.

#### **Disclosure of Information**

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

For more information about how to request this information, members should contact Customer Service. The toll-free telephone number can be found on the member's ID card.

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