
Introduction This section addresses the respective responsibilities of all physicians and providers who care for our members. As part of continuing quality improvement activity and in accordance with applicable state and federal requirements, the Plan will monitor provider performance against the standards outlined in this section and the provider agreement. These guidelines also reflect generally accepted standard of care practices.

Primary Care *Primary care* is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with members and practicing in the context of family and the community. (Institute of Medicine, 1994)

Primary Care Offices The Plan's network of Primary Care Physicians (PCPs) provides comprehensive primary care services to Plan members.

PCP offices participating in our network receive the following benefits:

- full support of the Provider Relations, Customer Service, Claims and Health Services departments;
- information on discharge planning; and
- access to the medical resources of our participating network of providers, hospitals and ancillary services.

Primary Care Physician Responsibilities The following is a summary of responsibilities specific to PCPs who render services to Plan members. Please also refer to the listing of responsibilities for all physicians in this section. Additional information can be found in your contract.

Primary Care Physicians will:

- coordinate, monitor and supervise the delivery of healthcare services to each member who has selected the PCP for primary care services;
- assure the availability of physician services to members in accordance with appointment scheduling;
- arrange for on-call and after-hours coverage (see “After-Hours Services” sub-section);
- ensure accessibility of services to members maintaining a ratio of members to full-time equivalent (FTE) physicians as follows: One FTE physician for up to 1,500 Healthy Choice, Family Health Plus or Child Health Plus members;
- provide access and opportunity for the Plan or its designee to thoroughly examine 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 a report of an encounter for each visit where the provider sees the member;
- record encounters using a CMS 1500 form;
- provide immunizations to Healthy Choice, Child Health Plus and Family Health Plus members assigned to the Plan;
- ensure members utilize network providers. If providers cannot find a participating provider to perform a covered service, they should contact the Utilization Management department to obtain coverage determination;
- ensure members are seen for an initial office visit

and assessment within the first 90 days of enrollment and assignment to the PCP; and

- ensure an adequate supply and provision of immunizations, in accordance with the childhood immunization schedule as approved by the Advisory Committee on Immunization Practices of the U.S. Public Health Service and the American Academy of Pediatrics or when it is shown to be medically necessary for the child's health.

Adult Health Screening

An adult screening is performed by a physician or healthcare provider to assess the health status of a member age 21 or older. It is used to detect and prevent disease, disability and other health conditions or monitor their progression(s). The adult member will receive an appropriate assessment and Plan intervention as medically indicated. Please reference WellCare's Adult New Member Physical form, located in the **Forms** section of this manual.

Well Child/Teen Health Check-Ups

Well Child/Teen Health Program (C/THP) Check-Ups are services that are aimed toward Medicaid recipients under the age of 21 to identify any existing medical conditions and to coordinate indicated treatment or therapeutic services.

Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The C/TH Program also requires that immunizations be given depending on the age and history of the child.

The Plan follows the recommendations of the American Academy of Pediatrics and the Surgeon General's General Advisory Committee on Immunization Practice, U.S. Public Health Service.

In addition to the Check-Up, the PCP should:

- inform the member when the Check-Up is due, in accordance with the periodicity schedule;

- refer the member, as indicated by the result of the Check-Up, to the appropriate provider for further assessment and/or treatment; and
- offer assistance in facilitating the appointments scheduled, including but not limited to, obtaining state-provided transportation when indicated.

Screening for Domestic Violence

Primary Care Providers should screen members to identify indicators of domestic violence in same-sex, as well as in heterosexual partnerships, during new patient visits, annual follow-up visits and/or when intimate partner violence is suspected. Screening tools on Domestic Violence are located in the **Forms** section of this manual and may be used when assessing such symptoms.

The New York State Protocol for Domestic Violence Screening in relation to HIV counseling, testing, referral and partner notification is located in the **Member and Provider Education** section.

Compliance with the domestic violence screening requirement will be continually monitored during the annual medical record audit. Additional information and resources are available at the New York State Office for the Prevention of Domestic Violence Web site:
<http://www.opdv.state.ny.us/professionals/index.html>.

Behavioral Health and Substance Abuse Screening

Primary Care Providers are required to screen members for symptoms of behavioral health/substance abuse problems. Providers are encouraged to use screening tools (i.e., PHQ-9, CAGE-AID) accepted by the medical community to satisfy this requirement.

We ask that providers incorporate the screening tool in the member's permanent medical record, as compliance with Behavioral Health/Substance abuse screening will be monitored during the annual medical record audit. A copy of PHQ-9, CAGE-AID and CRAFFT Screening Tools and instructions are available in the **Member and Provider Education** section of this manual.

Additional resources are located at the following Web sites:

NYC Adapted tool for Drug and Alcohol Screening and Intervention (includes CAGE-AID and CRAFFT)

<http://home2.nyc.gov/html/doh/downloads/pdf/csi/alcoholkit-hcp-guide-pocket.pdf>

The MacArthur Initiative on Depression and Primary Care - Depression Screening Tool PHQ-9

<http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/>

Smoking Cessation

Physicians influence the decisions members make about their health care. When you treat a member who smokes or a member contacts you for assistance in quitting smoking, we ask that you follow the Smoking Cessation Guideline adopted by WellCare of New York, Inc. A copy of the guideline is included in the **Member and Provider Education** section of this manual.

Lead Poisoning Prevention Program

New York State Public Health Law and Regulations, require pediatric health care providers to:

- screen one and two-year olds for blood lead levels as part of well-child care;
- assess other children six months to six years of age for risk of high dose exposure;
- test every child found, through risk assessment, to be at risk for lead exposure and any Medicaid enrollee from 36 to 72 months who has not been previously tested.
- provide parents with written documentation of blood lead testing.
- report all blood lead levels = 10 ug/dL to the NYC Department of Health and Mental Hygiene within 24 hours. (Providers using portable blood lead analyzers must report all test results.)

- provide appropriate medical management including follow-up blood lead testing, developmental surveillance and risk reduction education for children found to have blood lead levels = 10 ug/dL.

The New York City Department of Health Lead Poisoning Prevention Program guidelines and reporting information are available at:

<http://home2.nyc.gov/html/doh/html/lead/hcp.shtml>

The Physicians Handbook on Childhood Lead Poisoning Prevention can be found on the New York State Department of Health Web site:

<http://www.health.state.ny.us/environmental/lead/handbook/phpref.htm>

Lead Poisoning Prevention, Screening and Management guidance from the NYC Department of Health and Mental Hygiene is included in the **Member and Provider Education** section of this manual.

Preventive Pediatric and Adult Health Care

WellCare recommends that Primary Care Providers follow the preventive care guidelines set by the U.S. Preventive Services Task Force and the Recommendations for Pediatric Preventive Services of the American Academy of Pediatrics, including the Recommended Childhood Immunization Schedule and the NYS DOH recommended immunization schedule.

Recommendations for Preventive Pediatric Health Care, the CDC Recommended Immunization Schedule and WellCare's Adult Preventive Health Guidelines can be found in the **Member and Provider Education** section of this manual.

WellCare further requires that Primary Care Physicians provide and document the preventive care services required by the National Committee on Quality Assurance (NCQA) for HEDIS/Quality Assurance Reporting Requirements (QARR).

Preventive services required to satisfy the QARR measures include but are not limited to:

- childhood immunizations by age two
- lead screening by age two
- well child visits in the first 15 months of life
- well child visits in the third, fourth, fifth and sixth year of life
- adolescent well-care visits
- cervical cancer screening;
- breast cancer screening;
- comprehensive diabetes care;
- colorectal cancer screening;
- control of high blood pressure;
- cholesterol management for people with cardiovascular conditions;
- prenatal care;
- postpartum care;
- Chlamydia screening;
- annual dental visit; and
- appropriate testing for children with pharyngitis.

Rapid Testing for HIV and Strep

WellCare recommends use of the following Rapid Testing:

- **Rapid HIV Testing**

Offer HIV Testing to:

1. Any patient who is age 18-64 and repeat testing every 5 years.
2. Members who have had a high-risk sexual or injection drug experience since the previous HIV test should be offered testing as often as every six months.
3. Members who have an illness suggesting acute HIV infection.
4. All pregnant members.

Providers no longer have to conduct lengthy pre-test counseling. They need only provide the NYS informational

brochure or an informational video and be available to answer questions.

Rapid Strep Testing

WellCare follows the recommendations of the American Academy of Pediatrics (AAP) and the Infectious Disease Society of America (IDSA) and encourages its providers to use Rapid Strep Testing for members presenting with symptoms of Pharyngitis.

If your facility does not have a laboratory, you need to complete a NYS CLEP (Clinical Laboratory Evaluation Program) to obtain a limited laboratory permit. This permit will allow performance of Clinical Laboratory Improvement Amendment (CLIA) waived tests such as OraQuick Advance (CPT 86703) for HIV and QuickVue +Strep A (CPT 87880) for Rapid Strep. If you have a laboratory you must amend the permit to include rapid HIV and Strep testing. To request changes to your laboratory permit you must contact NYS DOH Wadsworth Center. If you are using conventional HIV testing you will still need to submit your test requests to LabCorp.

Tuberculosis Control Directly Observed Therapy (DOT)

The New York City Department of Health and Mental Hygiene (NYCDOHMH) provides specialized care to patients who have suspected or confirmed tuberculosis (TB), including tuberculin skin testing, outpatient medical and nursing services, home nursing services and directly observed therapy (DOT). DOT is now accepted as the standard of care for patients with tuberculosis and entails having a trained health care worker observe the patient take prescribed anti-TB medications. DOT services can be provided in Chest Centers, at patient's homes, places of work or other community sites. Patients enrolled in the program are more likely to complete their TB treatment and less likely to relapse.

Although TB/DOT is a non-covered service, WellCare is responsible for communicating, cooperating and coordinating clinical management of tuberculosis with the TB/DOT provider. Physicians are required to report to NYC Department of Health and Mental Hygiene (refer to **Compliance with Mandated Reporting Requirements** section) as well as inform WellCare when a member is

diagnosed with TB.

Compliance with Mandated Reporting Requirements

Managed Care organizations are required to make reasonable efforts to assure timely and accurate compliance by participating providers with mandated reporting requirements. WellCare expects participating providers to comply with all mandated reporting requirements.

The New York City Department of Health and Mental Hygiene's Universal Reporting Form lists diseases and reportable conditions and can be used for reporting most communicable conditions for which reporting is mandated, including TB, STDs (Sexually Transmitted Diseases), animal bites and various types of poisonings.

The New York City Universal Reporting Form and instructions are in the **Forms** section of this manual and can be accessed at the following Web site:

<http://home2.nyc.gov/html/doh/downloads/pdf/hcp/urf-0803.pdf>

Mandated conditions where the New York City Universal Reporting Form cannot be used are: HIV/AIDS; known contacts to persons with HIV; and window falls. Other mandated reporting requirements, reportable to the NYCDOHMH include Lead Test results, termination of pregnancy, immunizations.

Information on reporting these conditions can be found on the New York City Department Of Health Mental Hygiene List of Reportable Disease and Conditions and the Citywide Immunization Registry Fact sheet in the **Member and Provider Education** section.

For your reference, we have included the New York State Department of Health Communicable Disease Reporting Requirements (which includes applicable telephone numbers and instructions) in the **Member and Provider Education** section of this manual. To obtain copies of the New York State Communicable Disease Reporting Form contact the New York State Department of Health at 518-474-0548.

Diseases and Conditions that Must be Reported to the NYC Department of Health and Mental Hygiene

Physicians are required by Article 11 of the NYC Health code to report certain diseases, conditions and events to the New York City Department of Health and Mental Hygiene (refer to **Compliance with Mandated Reporting Requirements** section):

- HIV/AIDS and known contacts to persons with HIV/AIDS
- Animal bites
- Window falls
- Tuberculosis
- Immunizations (Citywide Immunization Registry)
- Lead Test results
- Termination of pregnancy
- Suspected/confirmed adverse events associated with smallpox vaccination
- Other communicable diseases

Immunization Registry

The New York City Health Code requires providers to report immunizations given to all people under 19 years of age and allows for reporting of immunizations given to people 19 years of age and over, with patient consent. The Citywide Immunization Registry (CIR) keeps immunization records of people vaccinated in New York City.

Information on NYC reporting requirements can be found online at www.nyc.gov/health/cir and the Citywide Immunization Registry Fact sheet in the **Member and Provider Education** section.

Early Intervention Program

The Early Intervention Program (EIP) offers a variety of therapeutic and support services to infants and toddlers with disabilities and their families including family training, counseling, home visits and parent support groups; special instruction; speech pathology and audiology; physical therapy; psychological services; nutrition services; social work services; vision services and assistive technology devices and services.

Health Care Providers are required to offer referrals for

interventions or evaluation, with permission from the child's parents or guardians of children with or at risk for developmental delay. The Early Intervention Program serves children from birth to age three. The NYCDOHMH Early Intervention Program Referral Form is included in the **Forms** section of this manual. Additional resources are available at the Web sites below:

New York City Department of Health and Mental Hygiene
online Early Intervention Referral form
<http://home2.nyc.gov/html/doh/downloads/pdf/earlyint/ei-referral-form.pdf>

Information on New York State EIP Information/Referrals
http://www.health.state.ny.us/community/infants_children/early_intervention/index.htm

Child Safety

Pediatric providers and/or their staff are asked to provide childhood safety education with every opportunity for anticipatory guidance. Caregivers should be educated with respect to:

- Child Abuse or maltreatment-see **Child Abuse** section
- SIDS risk reduction
- Lead Poisoning Prevention
- Window guards
- Burns Prevention
- Car Safety
- Medication and chemical safety

Other safety and injury prevention topics may include but are not limited to bicycle and scooter safety, school safety, and avoiding sports injury. Pediatric providers should also offer age appropriate counseling on safe sex, avoidance of drug and alcohol use and prevention of violence. Anticipatory guidance is routinely monitored as part of well child and adolescent visits required for HEDIS/Quality Assurance Reporting Requirements.

Child Abuse or Maltreatment

Physicians and other health care providers are mandated by law to report suspected child abuse or maltreatment to

Reporting

the New York State Central Register (SCR) of Child Abuse and Maltreatment. The telephone numbers are:
Mandated Reporter Hotline (800) 635-1522

Two counties run child abuse hotlines that may be used instead of the SCR:

Onondaga County (315) 422-9701
Monroe County (585) 461-5690

Verbal reports to any of the hotlines must be followed within 48 hours by a written report on Form LDSS-2221A. A copy is located in the **Forms** section of this manual.

Additional information on NYS Child Abuse guidelines mandated reporting regulations and copies of the reporting form are available at the New York State Office of Children and Family Services Web site: www.ocfs.state.ny.us.

**OB/GYN
Provider
Responsibilities:
Family Planning**

Family Planning and reproductive health services are free-access services that do not require a referral from the primary care provider. Members may obtain family planning and reproductive health services, HIV blood testing and pre-and post test counseling from Plan providers or from any appropriate Medicaid provider. Family planning and reproductive health services include these medically-necessary procedures (and related drugs/supplies), administered by a physician or certified nurse practitioner during the course of a family planning visit:

- contraception, including insertion/removal of an IUD, insertion/removal of Norplant and injection procedures involving pharmaceuticals such as Depo-Provera;
- sterilization;
- screening, related diagnosis and referral to participating provider for pregnancy;
- medically-necessary induced abortions and for New York City recipients, elective induced abortions (authorization required).

Vision Services	WellCare will allow its members to self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services and, for members diagnosed with diabetes, for an annual dilated eye (retinal) examination.
Diagnosis and Treatment of Tuberculosis	Enrollees may self-refer to public health agency facilities for the diagnosis and/or treatment of TB.
Primary and Preventive Obstetric and Gynecologic Care	WellCare shall not limit a female member's direct access to primary and preventive obstetric and gynecologic services from a qualified provider of such services of her choice from within the plan to less than two (2) examinations annually for such services or to any care related to a pregnancy. In addition, WellCare shall not limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition, provided that such qualified provider discusses such services and treatment plan with the enrollee's primary care practitioner in accordance with the requirements of the Plan. The Plan will notify, in writing, each female member of their access as described.
Lead Poisoning Prevention	<p>OB/GYN providers can educate members on ways to prevent lead exposure, and identify lead poisoning early through blood lead testing (see Lead Poisoning Prevention Program section). WellCare recommends providers providing prenatal care:</p> <ul style="list-style-type: none">• educate all pregnant women on how to prevent lead exposure;• test pregnant woman at risk of lead exposure;• assess all pregnant women for risk of lead exposure at the first prenatal visit.

**Prenatal and
Post Partum
Care**

Prenatal care will be provided in accordance with generally accepted standards of practice and services rendered in accordance with Subdivision 1, Section 2522 of the Public Health Law Part 85.40, Prenatal Care Assistance Program (PCAP).

In order to ensure continuity of care and early identification of need for case management services, providers will inform WellCare of pregnant members at the initial prenatal care visit. WellCare's Prenatal Notification form is located in the **Forms** section of this manual. A centralized prenatal care record will be established which documents the provision of care and services and which will include but not be limited to the following:

- Initial screening;
- Risk assessment;
- Individualized care plan;
- Psychosocial assessment;
- Nutritional assessment; and
- Prenatal diagnostic and treatment services.

Post partum care should be provided between 21 and 56 days post delivery.

PCAP standards require the following HIV services:

- Provide all pregnant women with HIV counseling and education;
- Offer pregnant women confidential HIV testing; and
- Provide the HIV positive woman and her newborn infant the following services or make the necessary referrals for these services;
 1. management of HIV disease;
 2. psychosocial support; and
 3. case management to assist in coordination of necessary medical, social and addictive services.

Interpretive Guidelines for Prenatal Care are located in the **Member and Provider Education** section and can be found on the New York State Department of Health Web site at:

<http://www.health.state.ny.us/nysdoh/perinatal/en/pcap.htm>

Member Rights and Responsibilities

WellCare members have specific Rights and Responsibilities. These should be posted in your office for all members to see. Please contact your Provider Relations Representative for a copy of the Member Handbook.

Advance Directives

In accordance with New York State law, members have the right to control decisions relating to their medical care; including the decision to refuse or withhold medical or surgical treatment or procedures to prolong their life. Accordingly, competent adult Plan members (age 18 years or older) should receive information concerning this provision and have the opportunity to sign an Advance Directive. This allows them to designate another person to make a decision should they become mentally or physically unable to do so. Forms should be made available in your offices and completed forms should be filed in the member's medical record.

A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive. Additional advance directives information and resources can be found on the New York State Web site at:

http://www.health.state.ny.us/regulations/task_force/health_care_proxy/guidebook/.

After-Hours Services

The PCP should 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 assure accessibility and availability, the Primary Care Physician provides one of the following:

- 24-hour answering service
- answering system with option to page the physician
- an advice nurse with access to the PCP or on-call physician

**Closing of
Physician Panel**

In order to open/close your panel to members, physicians are required to:

- submit the request, in writing, 90 days prior to closing of his or her panel;
- keep his or her panel open to all Plan members who received services prior to closing the panel; and
- submit a written notice of the re-opening of the panel, to include a specific effective date.

**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 out-of-network attending physician.

**PCP Request
for Transfer of
a Member**

A plan physician or provider may not seek or request to terminate their 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/member relationship. The physician or provider should provide adequate documentation in the member's medical record to support his or her efforts to develop and maintain a satisfactory provider/member relationship. If a satisfactory relationship cannot be established or maintained, the provider or physician continues 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 or physician's practice.

In the event a participating physician or provider desires to terminate their relationship with a Plan member, the physician or provider must submit adequate documentation to support that, although they have attempted to maintain a satisfactory provider and member relationship, the member non-compliance with treatment, or uncooperative/disruptive behavior, is impairing the ability to care for and treat the member effectively. The physician or provider must complete a "PCP Request for Transfer of a Member" form, attach supporting documentation, and fax both to the Customer Service Department at the form fax number. A copy of the form is available in the **Forms** section of this manual.

Specialist Responsibilities

Specialists are responsible for treating Plan members referred to them by the PCP and communicating with the Plan's UM Department for authorizations. They must also comply with the appointment scheduling time frames specified under the Physician Responsibilities area of this section. Additional responsibilities, applicable to all providers in the Plan network are found later in the section. Please review the list for specificity to your practice. Additional information can be found in your contract.

All Physicians/ Providers

The remainder of this section of the manual, beginning with the following summary, is an overview of responsibilities for which all Plan providers are accountable. (Please refer to your contract or contact your Provider Relations Representative for clarification of any of the following.)

All Physicians/Providers will:

1. Provide or coordinate healthcare services that meet generally recognized professional standards and the Plan guidelines in the areas of operations, clinical practice guidelines, medical quality management, customer satisfaction and fiscal responsibility.

2. Use physician extenders appropriately. Physician assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) may provide direct member care within the scope or practice established by the rules and regulations of the state of New York and Plan guidelines.
3. The sponsoring physician will assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
4. PAs and ARNPs should clearly identify their titles to members, as well as to other healthcare professionals.
5. Any member request to be seen by a physician, rather than a physician extender, must be honored at all times.
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 Plan.
7. Provider agrees to hold admitting privileges in at least one Participating Hospital or use an admitting panel or hospitalist designated by the Plan or make other suitable arrangements acceptable to the Plan.
8. Refer members to participating physicians or providers, except when they are not available, or when an emergency situation precludes their use.
9. Admit members only to participating hospitals, SNFs, and other inpatient care facilities, except when an emergency situation precludes their use.
10. Respond promptly to Plan requests for medical records in order to comply with regulatory requirements, and to provide any additional information about a case in which a member has filed a grievance or appeal.
11. Inform the Plan in writing within 24 hours of loss or

restriction of hospital privileges; loss or limit of DEA permit; loss of liability insurance; loss or restriction of license to provide health care in any state as well as actions taken by the state, JCAHO, or any regulatory body; loss or suspension of participation in the Medicaid program; any adverse action by a governmental body or professional liability action against Provider or entity which Provider has ownership interest.

12. Inform the Plan immediately of changes in tax identification numbers, telephone numbers, addresses, and any other change which would affect his or her status with the Plan.

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. Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as needed for compliance with state and federal law.
14. Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
15. Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in the Plan quality improvement guidelines. All entries in the member record must identify the date and the provider.
16. Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.
17. Communicate clinical information between Plan

providers in a timely manner. Communication effectiveness and efficiency 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 upon.

18. 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 regimens.
19. Not discriminate in any manner between Plan members and non-Plan members.
20. Fully disclose to members their treatment options and allow them to be involved in treatment planning and execution.
21. Identify members who 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. The provider 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. Contact your local Provider Relations representative for a list of plan-sponsored or community-based programs.

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

All consultations or discussions involving the member, or his or her case, should be conducted discreetly and professionally in accordance with the HIPAA Privacy and Security Rules effective April 14, 2003. All physician practice personnel should be trained on privacy and security rules. The practice should ensure that a policy and procedure is in place for confidentiality of members' protected health information and that the practice is following procedure or obtaining appropriate authorization from members to release protected health information.

All members have a right to confidentiality, and any healthcare professional or person who deals directly or indirectly with the member or his/her medical record must honor this right. Every practice is required to post in the office or provide to members their Notice of Privacy Practice. Employees who have access to member records and other confidential information are required to sign a “Confidentiality Statement.”

Confidential information includes:

1. Any communication between a member and a physician.
2. Any communication with other clinical persons involved in the member’s health, medical and mental care. Included in this category are:

All clinical data, i.e., diagnosis, treatment and any identifying information such as name, address, SSN, etc.

- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem.
- Any communicable disease (such as AIDS) or HIV testing that is protected under Federal or State law.

When a member enrolls in the Plan, his or her signature on the “Enrollment Form” automatically gives the health care provider permission to release his or her medical record to the Plan, other physicians in the plan network who are directly involved with the member’s treatment plan and agencies conducting regulatory or accreditation reviews.

Before any individual not working for the Plan may gain access to the member’s medical record, written authorization should be obtained from the member, member’s guardian or his or her legally authorized representative (except when there is a statute governing access to the record, or a subpoena, or a court order is involved. Disclosures without authorization or consent

may include, but are not limited to:

- armed services personnel
- attorneys
- law enforcement officers
- relatives
- a third-party payer
- public health official

Medical Records

Medical Record requirements and guidelines.

1. Safeguard member confidentiality in accordance with HIPAA, State and Federal guidelines, the Plan Quality Improvement and Risk Management Programs and professional practice standards.
2. Make the medical records available for quality care review studies by Plan reviewers and/or IPA for UR and QA, state and local regulatory agencies, NYSDOH authorized representatives of Centers for Medicare & Medicaid Services (CMS), and LDSS (Medicaid only) and organizations conducting accreditation audits.
3. Comply with Corrective Action Plan requirements imposed as the result of any such review or audit.
4. When a member changes his Primary Care Physician, to provide without charge, and in a timely manner, a copy of a transferring member's medical record to the new Primary Care Physician.

Confidentiality of HIV Related Information in the Medical Record

To ensure confidentiality of HIV related information providers should have policies and procedures to address:

- Initial and annual in-service education of staff and contractors;
- Identification of staff allowed access and limits of access;
- Procedure to limit access to trained staff

(including contractors);

- Protocol for secure storage (including electronic storage);
- Procedures for handling requests for HIV-related information;
- Protocols to protect persons with or suspected of having HIV from discrimination.

Appointment Scheduling

The following criteria complies with access standards:

1. Primary Care Providers will:

- Provide medical coverage 24-hours a day, seven days a week;
- Ensure scheduled appointments are seen within 60 minutes;
- Schedule emergent-care appointments immediately for the same day as the request;
- Schedule urgent care appointments within one day or the request;
- See non-urgent “sick” visits within 48-72 hours of the request;
- Schedule routine non-urgent, preventive care within four weeks of the request.

2. Specialist Care Providers should:

- Schedule emergency referral visits on the same day as the request;
- Schedule urgent referral within 24 hours of the request;
- Schedule routine non-urgent care within four

to six weeks.

Covering Physicians

In the event participating providers are temporarily unavailable to provide care or referral services to Plan members, you should make arrangements with another Plan-contracted and credentialed physician to provide these services on their behalf.

Should you have a covered physician who is not contracted and credentialed with the Plan, please obtain the Plan's approval. The physician should be credentialed by the Plan. He or she must sign an agreement accepting your negotiated rate and agree not to balance bill Plan members. For additional information, please contact your local Provider Relations department.

Referrals & Authorizations

It is the specialist's, hospital's and ancillary service provider's responsibility to verify that an appropriate referral has been obtained from the member's Primary Care Physician. A referral should always be obtained prior to delivering care for non-urgent/emergent services. See the **Utilization Management Section** of this manual for specific referral/pre-authorization instructions.

Payment may be withheld if the necessary referral or prior authorization is not obtained. Urgent or emergency treatment should be provided immediately, and the Primary Care Physician contacted as soon as possible (within 2 hours).

All inpatient admissions and services on the "Services Requiring Prior Authorization" list located in the **Utilization Management Section** of this manual require authorization by the Plan's Utilization Management (UM) Department. Hospital Representatives should contact the Plan's UM Department within 24 hours of a member admission.

Please refer to the **Utilization Management Section** of this manual for additional information regarding services which require prior authorization, and those that are excluded from the referral and prior authorization requirements.

Provider Billing and Address Changes

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

- tax identification number
- group name or affiliation
- physical or billing address
- telephone number

Liability Insurance

Physicians are responsible for maintaining comprehensive liability insurance to insure the physician and his or her employees against any claim for damages occasioned by the performance of medical services. To comply with state and federal guidelines, or as otherwise required, the physician must carry professional liability insurance with a minimum limit of \$1,300,000 to \$3,900,000.

Upon request, the physician/provider will provide Plan with evidence of coverage and any renewals, replacements, or changes.

Participation and Credentialing

All providers are accepted for participation if they meet the Plan's credentialing requirements and business needs of the company, at its sole discretion.

WellCare does not discriminate on the basis of race, color, gender, creed or national origin of the provider.

Participating providers are required to notify the Plan immediately when a new provider joins their practice. An application must be completed and notification should be communicated to your local Provider Relations Representative. Please refer to the **Credentialing** section to learn more about our Credentialing requirements.

Provider Termination

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

- Any contracted provider must ensure at least **90 days prior written** notice before invoking the "without cause" termination of a contractual agreement.

- Terminations occur on the last day of the month. For example: A termination letter is dated September 15. Termination is effective December 31.
- Providers who receive a termination notice from the Plan may submit an appeal. Please refer to the **Credentialing** section of the manual for specific guidelines.

Please Note: The Plan, due to regulatory requirements, must notify, in writing, all appropriate agencies and/or members upon a provider termination as required by regulations and statutes.

Preferred Drug List

Please refer to the **Pharmacy** section of this manual for a description of the Plan Preferred Drug List and prescribing criteria. Please contact your Provider Relations Representative for a copy of the list.

Utilization Management and Quality Improvement Programs

Under the terms of the contract for participation on the Plan network, providers agree, in addition to complying with state and federally-mandated procedures, to cooperate and participate in the Plan's UM/QI programs (peer review, provider or member grievance procedures, external audit systems, and administrative review). Providers will also comply with all final determinations rendered pursuant to the proceedings of the UM/QI programs.

Delegated Entities- Utilization Management

All participating providers or entities delegated for Utilization Management are to use the same standards as defined in the **Utilization Management** section of this manual. Compliance is monitored on a monthly basis and formal audits are conducted annually.

Clinical Practice Guidelines

WellCare, through its Medical Advisory Committee, reviews, updates and adopts clinical practice guidelines every two years or on an as-needed basis. These guidelines are based on nationally-accepted standards.

Participating providers are expected to adhere to guidelines adapted by WellCare to the extent possible. Guidelines are not meant to substitute for the sound, clinical judgment and decision-making required to address specific circumstances encountered in the course of rendering quality care to our members. Clinical Practice Guidelines adopted by the Plan are readily available by virtue of their already broad publication and distribution, and brief summaries of selected guidelines are available on WellCare's Web site.

The following list of guidelines and protocols adopted by WellCare can also be accessed online at:
www.wellcare.com.

Asthma

Guidelines for the Diagnosis and Management of Asthma – August 2007, Expert Panel Report (EPR) 3, National Heart and Lung Institute of the National Institute of Health.

The Guideline uses the 1997 EPR2 guidelines and the 2004 update of EPR2 as the framework. The guideline is organized around four essential components of asthma care, namely: Assessment and Monitoring; Patient education; Control of factors contributing to asthma severity and; Pharmacologic treatment.

The Guideline may be viewed or downloaded, free of charge, at the following Web site:
<http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>.

Chronic Heart Failure (CHF)

ACC/AHA Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult, a report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines (Committee to revise the 2001 Guidelines for the Evaluation and Management of Heart Failure) August 2005. The WellCare CHF Clinical Practice Guideline, based on the above-referenced standard, is included in the **Member and Provider Education** section. A downloadable copy of the CHF guidelines may be

obtained at:

<http://content.onlinejacc.org/cgi/reprint/46/6/e1>.

Chronic Kidney Disease

K/DOQI Clinical Practice Guidelines for Chronic Kidney Disease; Evaluation, Classification and Stratification, 2002. Clinical Practice Guidelines for Chronic Kidney disease in Adults Part I. Definition, Disease Stages, Evaluation, Treatment and Risk Factors 2004, American Academy of Family Physicians 2004:70:869-76. The WellCare CKD Clinical Practice Guideline, based on the above-referenced standard, is included in the **Member and Provider Education** section.

Depression

Clinical Practice Guideline Number 5: Depression in Primary Care 2: Treatment of Major Depression, US Department of Health and Human Services, Agency for Health Care Policy and Research: 1993 AHCPR publication 93-0551: 7, 28, 29, 109-112.

Diabetes

Standards of Medical Care in Diabetes, American Diabetes Association Position Statement, Diabetes Care, Volume 30, Supplement 1. January 2007.

Copies of the guideline may be downloaded from the Web site of the American Diabetes Association.

http://care.diabetesjournals.org/cgi/reprint/30/suppl_1/S4.

HIV/AIDS

The following are guidelines from the AIDS Institute that have been adopted by WellCare. Providers are expected to adhere to these and other Guidelines for the diagnosis, management and treatment of the HIV-Infected Patient published by the NYSDOH AIDS Institute.

General

1. How to Integrate Prevention into Primary Care, November 2005.

2. Health Promotion and Maintenance, July 2007.

Adult

1. Primary Care Approach to the HIV-infected Patient, March 2007.
2. Diagnostic, Monitoring and Resistance Tests for HIV, May 2005.
3. Antiretroviral Therapy, August 2007.
4. HIV Prophylaxis Following Occupational and Non-Occupational Exposure Including Sexual Assault December 2005.

Pediatric

1. HIV Testing and Diagnosis in Infants and Children, February 2005.
2. Pediatric Antiretroviral Therapy, July 2004.

To obtain paper copies of HIV/AIDS guidelines, you may use the order form for providers included in the **Forms** section of this manual.

To obtain online access to these and other downloadable HIV Clinical Guidelines from the New York State Department of Health/AIDS Institute, log onto <http://www.hivguidelines.org>.

Hypertension

7th Report of the Joint Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC7), August 2004.

The WellCare Clinical Practice Guideline, based on the above-referenced standard, is included in the **Member and Provider Education** section.

Oral Health Care During Pregnancy and Early Childhood

Oral Health Care During Pregnancy and Early Childhood Practice Guidelines, New York State Department of Health, August 2006. The recommendations contained in

these guidelines have been developed to assist health care professionals to educate women about oral health and to improve the overall health of women and children. These guidelines can be used by: 1) prenatal care providers to integrate oral health risk assessment into routine prenatal care; 2) oral health professionals to provide appropriate treatment to pregnant women; 3) child health professionals to incorporate oral health risk assessment into routine well-child care and provide referral if needed. The Guidelines may be downloaded by following the link:

http://www.health.state.ny.us/publications/0824/pda/windows_mobile/0824.pdf.

Prenatal Care Guidelines

Prenatal Care is provided to all pregnant women in accordance with 10 NYCRR Part 85.40, Prenatal Care Assistance Program (PCAP). A copy of the Prenatal Care Assistance Program Standards may be obtained by downloading from the NYS DOH Web site:

www.health.state.ny.us/nysdoh/perinatal/en/guidance.htm.

Preventive Care Guidelines

Guide to Clinical Preventive Services, Second Edition, Report of the U.S. Preventive Services Task Force, U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Disease Prevention and Health Promotion, 2007. A copy of the Guideline may be downloaded from the following Web site:

<http://www.ahrq.gov/clinic/pocketgd07/pocketgd07.pdf>.

Tuberculosis

Clinical Policies and Protocols, Bureau of Tuberculosis Control, New York City Department of Health, Third Edition, June 1999. Copies may be obtained from the New York City Department of Health at

<http://home2.nyc.gov/html/doh/downloads/pdf/tb/manu.pdf>.

Fraud and Abuse

What is Peer Profiling?

The WellCare Special Investigations Unit (SIU) performs a

multitude of pre-pay and post-pay functions. One of those specifically being Peer Profiling.

Peer profiling is primarily a post-pay function conducted using a myriad of analytical engines and driven by established norms within a specialty. For example, every pediatrician that provides services within the demographic for WellCare is pooled into one data set. The SIU is careful to remove pediatricians with sub-specialties so as not to include a pediatric cardiologist in with a straight pediatrician. We group each pediatric sub-specialty and perform that function separately.

From that data set our Data Analytics team is able to determine the bell curve and define the distribution for any range of codes. One of the most commonly profiled ranges of the SIU screen would be CPT codes 99211, 99212, 99213, 99214 and 99215.

Once established we focus our initial concern on the providers that have billing patterns two to three deviations from the norm, or also known as 'skewed right' of the bell curve. This normally triggers an audit or further investigation related to determining if the documentation supports the billing.

Special Investigations Unit

A corporate Special Investigations Unit (SIU) has been established according to federal and state statutory, regulatory and contractual requirements and includes management, investigators, analysts, medical coding auditors and claim review specialists. SIU capabilities include pre-payment and retrospective reviews, provider profiling models, performance metrics, data mining, analysis and reporting and specialized business partner arrangements to augment in-house resources.

The mission of the SIU is outlined below:

- Comply with applicable federal and state statutory, regulatory and contractual requirements regarding fraud, waste and abuse;
- Effectively detect, investigate and report suspected

fraud, waste and abuse;

- Identify and recover overpayments caused by error, fraud, waste or abuse;
- Assist in the development of anti-fraud plans, policies and procedures, and fraud and abuse awareness, education and training materials;
- Assist in conducting education and training for associates, providers, members, first-tier, delegated and related entities on fraud and abuse awareness and other related topics according to established training schedules; and
- Assist in conducting vulnerability assessments, auditing and monitoring activities of first-tier, delegated and related entities.