

2011 Medicare Advantage Provider Manual

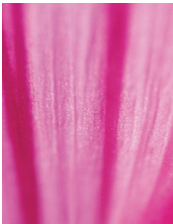


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Please note that the most up-to-date Medicare Advantage provider manual is located on WellCare's website at:
<http://www.wellcare.com/Provider/ProviderManuals>

I. Overview

About WellCare

WellCare Health Plans, Inc. and Harmony Health Plan, Inc. (WellCare) provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid and Medicare, including prescription drug plans and health plans for families, and the aged, blind and disabled. WellCare's corporate office is located in Tampa, Florida. As of December 31, 2010, we served approximately 2.2 million members. Our experience and our exclusive commitment to these programs enable us to serve our members and providers as well as manage our operations effectively and efficiently.

Purpose of this Manual

This Medicare Advantage Provider Manual is intended for WellCare-contracted ("participating") Medicare providers providing health care service(s) to WellCare Medicare Advantage members enrolled in a WellCare Medicare Advantage plan. This manual serves as a guide to the policies and procedures governing the administration of WellCare's Medicare Advantage plans and is an extension of and supplements the Provider Participation Agreement ("Agreement") between WellCare and health care providers, who include without limitation: physicians, hospitals and ancillary providers (collectively, "Providers"). **This manual replaces and supersedes any previous versions dated prior to May 24, 2011 and is available on WellCare's website on <http://www.wellcare.com/Provider/ProviderManuals>** A paper copy, at no charge, may be obtained upon request.

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

WellCare's Medicare Advantage

As a Medicare Advantage (MA) plan, coverage includes all of the benefits traditionally covered by Medicare plus added benefits identified in coverage documents. Such additional benefits may include*:

- No or low monthly health plan premiums with predictable co-pays for in-network services;
- Outpatient prescription drug coverage, including Tier 1 drugs through the coverage gap;
- Routine dental, vision and hearing benefits; and
- Preventive care from participating providers with no co-payment.

**Subject to change. Availability varies by plan and county.*

Our Products

Our products are designed to offer enhanced benefits to our members as well as cost sharing alternatives. Starting in 2008, additional HMO plan options such as Point-of-

Service (POS), Concentric Network options, and the Preferred Provider Organization (PPO) plan were available in select areas. Most recently, WellCare began offering a Dual Special Needs Plan (DSNP) in select areas.

These products are offered in selected markets to allow flexibility and offer a distinct set of benefits to fit member needs in each area. Please refer to the state-specific Quick Reference Guides for product information which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>. Below is a list of distinctions (not all-inclusive) among our Medicare Advantage products.

HMO – WellCare's traditional Medicare Advantage plan. All services must be provided within the WellCare network unless an emergency or urgent need for care arises, or such service is not available in-network. Some services require prior authorization by WellCare, or its designee.

HMO with POS Option (HMO/POS) – Members may choose to visit out-of-network providers for selected specialty, ancillary and hospital services. Out-of-network services may require authorization by WellCare. Member cost share for covered out-of-network services is a coinsurance or percentage of the payment made by WellCare.

HMO/POS with Concentric Network – Members have access to expanded benefits not traditionally covered by Medicare. Members must choose a Primary Care Physician (PCP) from a subset of WellCare network PCPs. Some services require authorization by WellCare.

PPO – Allows members to visit in-network or out-of-network providers for covered services. Some in-network services require authorization by WellCare. Out-of-network services do not require authorization. However, notification to WellCare is recommended for verification of benefits or when emergency care was needed. Member cost share for out-of-network services is a coinsurance or percentage of the payment made by WellCare.

DSNP – A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Provider Services

Providers may contact the appropriate departments at WellCare by referring to the state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

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

WellCare.com

On WellCare's website www.wellcare.com providers will have access to a variety of easy-to-use tools created to streamline day-to-day administrative tasks with WellCare. Additional resources found on the website include:

- Clinical Practice Guidelines
- Clinical Coverage Guidelines

- Newsletters
- Training Materials and Job Aids
- Member Rights and Responsibilities
- Privacy Statement and Notice of Privacy Practices

Registration is required to utilize certain key features.

Key Features and Benefits

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

Claims Submission Status and Inquiry

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

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

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

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

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

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

Provider & Pharmacy Look-Up – Search the online Provider Directory by geographic location and medical specialty to refer members to in-network services.

Provider Manuals – A complete copy of WellCare's Provider Manuals are available online, including all of the necessary forms and education materials. For more information, refer to the state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

Your Registration Advantage

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

How to Register

To register, refer to the state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>. For more information about WellCare Web capabilities, please contact the Customer Service department or contact Provider Relations to schedule a website in-service.

II. Provider and Member Administrative Guidelines

Provider Administrative Overview

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

Participating WellCare Medicare Providers, must in accordance with generally accepted professional standards:

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

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

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

Responsibilities of All Providers

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

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. Living will and advance directive rights may differ between states.

Each WellCare 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.

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

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

Provider Billing & Address Changes

Prior notice to your Provider Relations representative or Customer Service 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 the Agreement, you must adhere to the following terms:

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

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

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

Out-of-Area Member Transfers

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

Members with Special Health Care Needs

Members with Special Health Care Needs include members with the following conditions:

- Mental retardation or related conditions;
- Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes; 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.

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

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

Responsibilities of Primary Care Physicians (PCP)

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

- Coordinate, monitor and supervise the delivery of primary care services to each member;
- Provide or arrange for coverage of services, consultation or approval for referrals twenty-four (24) hours per day, seven (7) days per week. To ensure accessibility and availability, PCPs must provide one of the following:
 - A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
 - Answering system with option to page the physician; or
 - An advice nurse with access to the PCP or on-call physician.
- The PCP must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the member's needs;
- WellCare shall monitor providers against these standards to ensure members can obtain needed health services within the acceptable appointments and in-office waiting times and after-hours. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare;

PCP - Urgent	< 24 hours
PCP - Non-Urgent	< 1 week
PCP - Routine	< 30 days
WAIT TIMES	< 30 minutes

- Assure members are aware of the availability of public transportation where available;
- Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity.

A related organization or entity is defined as: having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;

- Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Health Plan Employer Data and Information Set) service;
- Submit encounters. For more information on encounters, refer to *Section III. Claims*;
- Ensure members utilize network providers. If unable to locate a participating WellCare Medicare Advantage provider for services required, contact Health Services for assistance. Refer to the state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>
- See members for an initial office visit and assessment within the first ninety (90) days of enrollment in WellCare;
- Comply with and participate in corrective action and performance improvement plan(s).

Primary Care Offices

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

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

Closing of Physician Panel

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

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

Covering Physicians/Providers

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

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

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

Termination of a Member

A WellCare 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 WellCare's member.

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

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

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

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 manual.

Smoking Cessation

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 WellCare.

Adult Health Screening

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

Member Administrative Guidelines

Overview

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

Evidence of Coverage Booklet

All newly enrolled members will receive an Evidence of Coverage booklet within ten (10) calendar days of receiving the notice of enrollment from WellCare. WellCare will mail all enrolled members an Evidence of Coverage booklet annually thereafter.

Enrollment

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

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

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

Member Identification Cards

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

Eligibility Verification

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

Providers may do one of the following to verify eligibility:

- Access the WellCare website at www.wellcare.com
- Access WellCare's Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility; and/or
- Contact the Customer Service Department.

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See your Agreement for additional details.

Member Rights and Responsibilities

WellCare members, adults and children have specific Rights and Responsibilities. These are included in the Evidence of Coverage booklet.

WellCare members have the right to:

- Have information provided in a way that works for them including information that is available in alternate languages and formats;
- Be treated with fairness, respect, and dignity;

- See WellCare providers, get covered services and get their prescriptions filled in a timely manner;
- Privacy and to have their personal health information protected;
- Get information about WellCare, WellCare's network of providers, their drug coverage and costs, their covered services, and their rights and responsibilities;
- Know their treatment choices and participate in decisions about their health care;
- Use advance directives (such as a living will or a power of attorney);
- Make complaints about WellCare or the care provided and know that it will not affect the way they are treated.
- Appeal medical or administrative decisions WellCare has made by using the grievance process;
- Make recommendations about WellCare's rights and responsibilities policies; and
- Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. The information must be given in a way they understand.

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

- Become familiar with their coverage and the rules they must follow to get care as a member;
- Tell WellCare if they have any other health insurance coverage or prescription drug coverage in addition to WellCare;
- Tell their PCP and other health care providers that they are enrolled in WellCare;
- Give their PCP and other providers the information they need to care for them, and to follow the treatment plans and instructions that they and their providers agree upon;
- Understand their health problems
- Ask their PCP and other providers if they have any questions and to explain their treatment in a way they understand;
- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals and other offices;
- Pay their plan premiums and any co-payments or coinsurance they owe for the covered services they get. Members must also meet their other financial responsibilities as described in the Evidence of Coverage booklet; and
- Inform WellCare of any questions, concerns, problems or suggestions by calling the Customer Service phone number listed in their Evidence of Coverage booklet.

Assignment of Primary Care Physician

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

PPO members are not required to choose a PCP from WellCare's network, although they may elect to do so.

Changing Primary Care Physicians

Members may change their PCP selection at any time by calling Customer Service.

Women's Health Specialists

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

Hearing- Impaired, Interpreter and Sign Language Services

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

III. Claims

Overview

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

Timely Claims Submission

Unless otherwise stated in the Provider Participation Agreement ("Agreement"), Provider must submit claims (initial, corrected and voided) within sixty calendar (60) days from the date of service for outpatient services and the date of discharge for inpatient services. Unless prohibited by federal law or CMS, WellCare may deny payment for any claims that fail to meet WellCare's submission requirements for Clean Claims or that are received after the time limit in the Agreement for filing Clean Claims.

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

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

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

- SNIP Rejection Letter;
- A copy of the Provider's billing screen.

Tax ID and NPI Requirements

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

Taxonomy

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

Preauthorization number

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

National Drug Codes (NDC)

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

Strategic National Implementation Process (SNIP)

All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines. The SNIP validations used by WellCare to verify transaction integrity/syntax are available in the Forms section of this manual and on our website.

If a claim is rejected for lack of compliance with WellCare's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information on *Encounters* see page 18.

Claims Submission Requirements

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

Electronic Claims Submissions

WellCare accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to WellCare must be in the ANSI ASC X12N format, version 4010A, or its successor. For more information on EDI implementation with WellCare, refer to the Wellcare Companion Guides which may be found on WellCare's website at www.wellcare.com/Provider/ClaimsUpdates

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouses, refer to the WellCare Job Aids, which may be found on WellCare's website at http://www.wellcare.com/Provider/job_aids

A unique WellCare Payer ID was included in your welcome letter from WellCare. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on the WellCare Payer IDs or to contact WellCare's EDI team, refer to the state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

HIPAA Electronic Transactions and Code Sets

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

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

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

Paper Claims Submissions

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

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

- Dot matrix font.

Claims Processing

Readmission

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

72-Hour Rule

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

Disclosure of Coding Edits

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

Prompt Payment

Refer to your Agreement.

Rate Updates

WellCare will implement and prospectively apply changes to WellCare's Medicare rate schedules based on CMS's rate changes (a) on the CMS effective date, if CMS publishes the rate change at least forty-five (45) calendar days prior to the CMS effective date, or (b) no more than forty-five (45) calendar days after the date CMS publishes the rate change, if the publication date is less than forty-five (45) calendar days before or after CMS's effective date. WellCare will not retrospectively apply increases or decreases to WellCare's Medicare rate schedule to any claims that have already been paid.

Coordination of Benefits

WellCare shall coordinate payment for Covered Services in accordance with the terms of a member's Benefit Plan and applicable state and federal laws and CMS guidance.

Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to WellCare. WellCare may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow WellCare policies and procedures regarding subrogation activity.

Members under the Medicare line of business may be covered under more than one insurance policy at a time. In the event:

- A claim is submitted for payment consideration secondary to primary insurance carrier, other primary insurance information, such as the primary carrier's Explanation of Benefits ("EOB"), must be provided with the claim. To submit other insurance information electronically, refer to the Wellcare Companion Guides which may be found on WellCare's website at www.wellcare.com/Provider/ClaimsUpdates
- WellCare has information on file to suggest the member has other insurance, WellCare may deny the claim;
- The primary insurance has terminated, the provider is responsible for submitting the initial claim with proof that coverage was terminated. In the event a claim was denied for other coverage, the provider must resubmit the claim with proof that coverage was terminated;
- Benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds WellCare's liability, no additional payment will be made.

The Order of Benefit Determination grid below for WellCare Medicare members outlines when WellCare would be the primary or secondary payer:

Order of Benefit Determination

Member	Condition	Pays First (Primary)	Pays Second (Secondary)
Age 65 or older and covered by a group Health Plan because of work or covered under a working spouse of any age	Employer has 20 or more employees	Other Coverage	WellCare
Age 65 or older and covered by a group Health Plan because of work or covered under a working spouse of any age	Employer has less than 20 employees	WellCare	Other Coverage
Age 65 or older and covered by a group Health Plan after retirement	Has Medicare Coverage	WellCare	Other Coverage

Disabled and covered by a large group Health Plan from work or from a family member working	Employer has 100 or more employees	Other Coverage	WellCare
Has End-Stage Renal Disease (ESRD) and group Health Plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Other Coverage	WellCare
Has End-Stage Renal Disease (ESRD) and group Health Plan coverage (including a retirement plan)	After 30 months	WellCare	Other Coverage
Has End-Stage Renal Disease (ESRD) and group Health Plan coverage and COBRA coverage	First 30 months of eligibility or entitlement to Medicare	Other Coverage	WellCare
In an accident where no-fault or liability insurance is involved	Entitled to Medicare	Other Coverage	WellCare
Workers' compensation/ Job related illness or injury	Entitled to Medicare	Other Coverage	Non-Covered Medicare service
Veteran with Veteran benefits	Entitled to Medicare & Veterans' benefits	Other Coverage	Non-Covered Medicare service
Covered under TRICARE	Service from a military hospital or other federal provider	Other Coverage	Non-Covered Medicare service
Covered under TRICARE	Covered Medicare services not provided by a military hospital or federal provider	WellCare	Other Coverage
Black lung disease & covered under the Federal Black Lung Program	Entitled to Medicare & Federal Black Lung Program	Other Coverage	WellCare
Age 65 or over or disabled & covered by Medicare & COBRA	Entitled to Medicare	WellCare	Other Coverage

Encounters Data

Overview

This section is intended to provide Delegated Vendors and Delegated Providers (IPAs) with the necessary information to allow them to submit encounter data to WellCare. If

encounter data does not meet the Service Level Agreements (SLA) for timeliness of submission, completeness or accuracy, state agencies have the ability to impose significant financial sanctions on WellCare. WellCare requires all delegated vendors and delegated providers to submit encounter data, even if they are reimbursed through a capitated arrangement.

Timely Encounters Submission

Unless otherwise stated in the Agreement, vendors and providers should submit complete and accurate encounter files to WellCare by the 10th of each month following the paid month or 10th of each month following the month of service for capitated encounters.

- Submission can be either weekly or monthly;
- Capitated entities will submit within ten (10) calendar days of the month of service;
- Non-capitated entities will submit within ten (10) calendar days of the paid month.

Accurate Encounters Submission

All encounter transactions submitted via direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines. Once WellCare receives a delegated vendor's or Provider's encounters, the encounters are loaded into WellCare's Encounters System and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

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

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

Complete Encounter Submission

Delegated vendors and providers are required to report 100% of the encounters.

Delegated vendors and providers are required to submit Cash Disbursement Journals (CDJ's) on a monthly basis which will account for all services provided. CDJ's will provide WellCare a summary of all claim/encounter submissions.

- Submission can be either weekly or monthly.
- Capitated entities will submit within fifteen (15) calendar days of the month of service.
- Non-capitated entities will submit within fifteen (15) calendar days of the paid month.

Encounters Submission Methods

Delegated vendors and providers may submit encounters using several methods: electronically, through one of WellCare's contracted clearinghouses, using WellCare's

Provider Portal for claims submission or using WellCare's Secure File Transfer Protocol (SFTP) and process.

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

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

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouses, refer to the WellCare Job Aids, which may be found on WellCare's website at http://www.wellcare.com/Provider/job_aids

A unique WellCare Payer ID was included in your welcome letter from WellCare. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on the WellCare Payer IDs or to contact WellCare's EDI team, refer to the state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

Submitting Encounters Using Direct Data Entry (DDE)

Delegated vendors and providers may submit their encounter information directly to WellCare using WellCare's Direct Data Entry portal. The DDE tool can be found on the Provider Portal at <http://www.wellcare.com/provider/default>.

Encounters Data Types

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

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

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

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

- New Encounter - A new encounter is an encounter that has never been submitted to WellCare previously.
- Voided Encounter - A voided encounter is an encounter that WellCare deletes from the encounter file and is not submitted to the state.

- Replaced or Overlaid Encounter - A replaced or overlaid encounter is an encounter that is updated or corrected within the WellCare system.

Member Expenses and Maximum Out of Pocket

The provider is responsible for collecting member expenses. Providers are not to bill members for any items or services, such as missed appointments or administrative fees. If a provider collects member expenses determined to exceed the member's responsibility, the provider must reimburse the member the excess amount. The provider may determine an excess amount by referring to the Explanation of Payment (EOP).

For certain Benefit Plans, member expenses are limited by a maximum out of pocket ("MOOP") amount. If a provider collects member expenses in excess of the MOOP, the provider is responsible for reimbursing such member the member expenses collected in excess of the MOOP amount under such member's Benefit Plan. WellCare will notify a provider of the affected member and the amount in excess of MOOP and the provider will promptly reimburse the member for the amount in excess of MOOP. If WellCare determines that the provider did not reimburse the amount in excess of MOOP to the member as required by this section, WellCare may pay such amount due to the member directly, and recoup the amount from the provider in accordance with the Overpayment section in this manual. If WellCare has deducted any member expenses from the provider reimbursement in excess of the MOOP amount, WellCare will reimburse the provider for the amount deducted. WellCare may audit providers' compliance with this section and may require a provider to submit documentation to WellCare supporting that the provider reimbursed members for amounts in excess of MOOP.

Balance Billing

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

Hold Harmless Dual Eligibles

Those Dual Eligible members whose Medicare Part A and B member expenses are identified and paid for at the amounts provided for in the State Medicaid Plan by the applicable state Medicaid agency shall not be billed for such Medicare Part A and B Member Expenses, regardless of whether the amount a provider perceives is less than the allowed Medicare amount or Provider charges are reduced due to limitations on additional reimbursement provided in the state Medicaid plan. Providers shall accept WellCare's payment as payment in full or will bill the appropriate state source if WellCare has not assumed the state's financial responsibility under an agreement between WellCare and the state.

Non-covered Services

Hospital Acquired Conditions and Surgical Never Events

WellCare follows CMS guidelines regarding Hospital Acquired Conditions and Surgical Never Events. The hospital may not bill, attempt to collect from, or accept any payment from WellCare or the member for such events.

CMS requires hospitals identify and document secondary diagnoses that are present on admission (“POA”) in order to differentiate between conditions present on admission and conditions that develop during an inpatient admission. WellCare will reject claims if the POA value is not present.

Medicare does not cover a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs: (a) a different procedure altogether; (b) the correct procedure but on the wrong body part, or; (c) the correct procedure on the wrong patient.

Medicare will not cover hospitalizations and other services related to the non-covered procedures, including:

- All services provided in the operating room when an error occurs are considered related and not covered;
- All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment;
- All related services provided during the same hospitalization in which the error occurred are not covered.

Hospitals are required to bill two (2) claims when a Never Event is reported, including:

- One claim with covered services(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (“TOB”) 11X (with the exception of 110), and;
- The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(s) on a 110 TOB (no-pay claim).

Each covered and non-covered claim must have matching “Statement Covers Period”. TOB 110 must have one (1) of the following ICD-9-CM diagnosis code reported in diagnosis position 2-9:

- E876.5 – Performance of wrong operation (procedure) on correct patient (existing code);
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery;
- E876.7 – Performance of correct operation (procedure) on wrong side/body part.
Note: These codes are not to be reported in the External Cause of Injury (E-code) field.

Outpatient, Ambulatory Surgical Centers, other Appropriate Bill Types and Practitioner Claims are required to bill one (1) of the following modifiers to all lines related to the erroneous surgery(ies):

- PA: Surgery Wrong Body Part;
- PB: Surgery Wrong Patient;
- PC: Wrong Surgery on Patient.

Reopening and Revising Determinations

A reopening request must be made in writing, clearly stating the specific reason for requesting the reopening. It is the responsibility of the provider to submit the requested documentation within sixty (60) days of the denial to re-open the case.

All decisions to grant reopening are at the discretion of WellCare. See the Medicare Claims Processing Manual, Chapter 34, for Reopening and Revision of Claim Determinations and Decisions guidelines.

Disputed Claims

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

Documentation consists of: (a) Date(s) of service; (b) Member name; (c) Member WellCare ID number and/or date of birth; (d) Provider name; (e) Provider tax id; (f) Total billed charges; (g) the Provider's statement explaining the reason for the dispute, and; (h) Supporting documentation when necessary (e.g. proof of timely filing, medical records).

To initiate the process, please mail or fax the written claim payment dispute and documentation to:

"State Specific Plan Name"
Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3372
Fax Number: (877) 277-1808

Corrected Claims or Voided Claims

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

To submit a Corrected or Voided Claim electronically:

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

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

To submit a Corrected or Voided Claim via paper:

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

Example:

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

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

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

64 DOCUMENT CONTROL NUMBER
298370064

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

Example:

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

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

The Correction or Void Process involves two transactions:

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

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

Reimbursement

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

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

- **Incidental Surgeries/Complications:** A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a WellCare Medical Director on whether the proposed complication merits additional compensation above the usual allowable amount.

- **Admission Examination:** One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follow-up Surgery Charges:** Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- **Multiple Procedures:** Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.
- **Assistant Surgeon:** Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies. WellCare uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes”, CMS is used as the secondary source.
- **Co-Surgeon:** Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his/her distinct, operative work, by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier ‘62’ added.

Modifier

WellCare follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Allied Providers

WellCare follows CMS reimbursement guidelines regarding Allied Health Professional.

Medicare Overpayment Recovery

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

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will follow the same methodology used by the CMS Recovery Audit Contractor (RAC) program by limiting its recovery to three (3) years from the date of service. In all cases, WellCare or one of its business partners will provide a written notice to the provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. The standard request notification provides forty-five (45) calendar days for the provider to send in the refund, request further information or dispute the overpayment. For more information on the CMS RAC, refer to the CMS website at <http://www.cms.gov/RAC/>

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

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

WellCare Health Plans, Inc.
8735 Henderson Road
Renaissance 2
Tampa, FL 33634

or contact WellCare Customer Service to arrange an off-set against future payments. For more information on contacting Wellcare Customer Service, refer to the state-specific Quick Reference Guides which may be found on WellCare’s website at: <http://www.wellcare.com/Provider/QuickReferenceGuides>

Benefits During Disaster and Catastrophic Events

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – WellCare will:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A/B benefits must, per 42 CFR 422.204(b)(3), be furnished at Medicare certified facilities);
- Waive in full, requirements for authorization or pre-notification;
- Temporarily reduce plan-approved out-of-network cost sharing to in-network cost sharing amounts;
- Waive the thirty (30) calendar day notification requirement to enrollees as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the member.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed thirty (30) calendar days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, WellCare should resume normal operations thirty (30) calendar days from the initial declaration.

IF:	THEN:
An institutional claim:	<i>Condition Code</i> will be DR or Modifier CR
A professional claim:	<i>Modifier</i> will be CR Code

IV. Credentialing

Overview

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

This review includes (as applicable to practitioner type):

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

Practitioners are required to be credentialed prior to being listed as participating network providers of care or services to WellCare members.

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

Please take note of the following credentialing process highlights:

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

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

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

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

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

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

Practitioner Rights

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

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

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

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

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

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

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

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

WellCare's written notification to the practitioner includes:

- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;

- The addressee in Credentialing to whom corrections must be sent;
- WellCare’s documentation process for receiving the correction information from the provider; and
- WellCare’s review process.

Baseline Criteria

Baseline criteria for practitioners to qualify for provider network participation:

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

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

Work History – Practitioners must provide a minimum of five years’ relevant work history as a health professional.

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

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

Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare Company Plan. Existing providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with WellCare policy and procedure.

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

Liability Insurance

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

CT, GA, IL, MO, NJ, NY & OH,	\$1,000,000/\$3,000,000 per provider
FL & IN	\$250,000/\$750,000 per provider
LA	\$100,000/\$300,000 per provider

TX	\$200,000/\$600,000 per provider
HI	\$1,000,000/\$3,000,000 per individual
HI	\$2,000,000/\$2,000,000 per facility

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

Site Inspection Evaluation (SIE)

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

- Office-site criteria
 - Physical accessibility
 - Physical appearance
 - Adequacy of waiting room and examination room space
- Medical / treatment record keeping criteria

SIE's are conducted for:

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

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

Covering Physicians

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

Allied Health Professionals

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

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

- Advanced Registered Nurse Registered Nurse Practitioners (ARNP)
- Certified Nurse Nurse Midwife (CNM)
- Physician Assistant (PA)
- Osteopathic Assistant (OA)

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

- Licensed clinical social worker
- Licensed mental health counselor
- Licensed marriage and family therapist
- Physical therapist
- Occupational therapist
- Audiologist

- Speech/language therapist/pathologist

Ancillary Health Care Delivery Organizations

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

Re-Credentialing

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

Updated Documentation

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

Office of Inspector General Medicare/Medicaid Sanctions Report

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

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

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

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

Participating Provider Appeal through the Dispute Resolution Peer Review Process

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

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

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

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

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

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

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

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

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

The practitioner and WellCare are entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there from, are arbitrary, unreasonable or capricious.

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

In the event the findings of the first level Panel hearing are adverse to the practitioner, the practitioner may access the second level Peer Review Panel by following the notice

information contained in the letter notifying the practitioner of the adverse determination of the first level Peer Review Panel.

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

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

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

Delegated Entities

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

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

Utilization Management

Overview

The Utilization Management (UM) Program defines and describes WellCare's multidisciplinary, comprehensive approach and process to manage resource allocation. The UM Program describes the use of Health Services review guidelines, WellCare's adverse determination process, the assessment of new technology, and delegation oversight.

The utilization management program includes components of prior authorization, prospective, concurrent and retrospective review activities, each designed to provide for evaluation of health care and services based on member coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to providers of care.

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

Prior Authorization

WellCare provides a process to make a determination of medical necessity and benefits coverage for inpatient and outpatient services prior to services being rendered. Prior Authorization requirements are applicable for pre-service decisions.

For more information on the appropriate fax, phone numbers, web address for submitting requests, and Inpatient, Outpatient and Ancillary Services Authorization Request Forms refer to the state-specific Quick Reference Guide which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

Providers may submit requests for authorization by:

- Faxing a properly completed Inpatient, Outpatient, or Ancillary Services Authorization Request Form; or
- Requesting, via telephone, selected services, including urgent requests; or
- Requesting services using the Web-based process.

It is necessary to include the following information in the request for services:

- Member name and identification number;
- The requesting provider's demographics;
- Diagnosis Code(s) and Place of Service;
- Services being requested and CPT Code(s);
- The recommended provider's demographics to provide the service;
- A history and any pertinent medical information related to the request, including current plan of treatment, progress notes as to the necessity, effectiveness, and goals.

Prior Authorization for members enrolled in a Point of Service (POS) Plan:

The POS option allows members of designated products to use providers outside of the WellCare network for additional cost. The member will pay more to access services outside the network except for emergency services. The member's Primary Care Physician (PCP) must be in the network of providers and must request an authorization for all service requests under the POS option. The PCP must request the activation of the POS option and inform the member that there is a higher cost-sharing.

Prior Authorization requests will be reviewed for availability under the POS option, medical necessity and network adequacy. Authorization requests will be processed as an in-network authorization if a network inadequacy is found.

Concurrent Review

WellCare provides a process for the oversight and evaluation of member status when admitted to hospitals, rehabilitation centers and skilled nursing facilities, including continued inpatient stays to monitor appropriate utilization of health care resources and promote quality outcomes for members.

WellCare provides oversight for members receiving acute inpatient services in a hospital, rehabilitation center or skilled nursing facility to determine the initial/ongoing medical necessity, appropriate level of care, appropriate length of stay and to facilitate a timely discharge.

The concurrent review process is conducted based on the member's medical condition.

Concurrent review decisions are made utilizing the following criteria:

- InterQual SI/IS criteria
- WellCare Clinical Coverage Guidelines
- Ingenix Guide to Medicare Coverage Issues

These review criteria are utilized as guidelines and decisions will take into account the member's medical condition and co-morbidities. The review process is performed under the direction of the WellCare Medical Director.

Frequency of onsite and/or telephonic review will be based on the clinical condition of the member. The frequency of the reviews for extension of initial determinations is based on the severity/complexity of the patient's condition, necessary treatment, and discharge planning activity including possible placement in a different level of care.

The treating provider and the facility Utilization Review staff will provide review information that is collected telephonically or via fax.

Clinical information is requested to support the appropriateness of the admission, continued length of stay, level of care, treatment plans and discharge plans

Discharge Planning

WellCare identifies and provides the appropriate level of care as well as medically necessary support services for members upon discharge from an inpatient setting. Discharge planning begins upon notification of the member's inpatient status to facilitate continuity of care, post-hospitalization services, referrals to a Skilled Nursing Facility or Rehabilitation Facility, evaluating for a lower level of care, and maximizing services in a cost-effective manner. As part of the Utilization Management process, WellCare will provide for continuity of care when transitioning members from one level of care to another. The discharge plan will include a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional setting. This will be based on the information received from the institution and/or provider caring for the member.

Some of the services involved in the discharge plan include but are not limited to:

- Durable Medical Equipment (DME)
- Transfers to an appropriate level of care (such as an Inpatient Nursing Rehabilitation (INR) Facility, Long Term Acute Care (LTAC) Facility or Skilled Nursing Facility/SNF)
- Home Health Care
- Medications
- Physical, Occupational, or Speech Therapy

Retrospective Review

A retrospective review is any review of care or services that have already been provided. WellCare will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions and taking into account the member's needs at the time of service. WellCare will also identify quality issues, utilization issues and the rationale behind failure to follow WellCare's prior authorization/pre-certification guidelines.

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

Criteria for Utilization Management Determinations

Utilization Medical Criteria are based on current clinical principles and processes. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay.

The medical review criteria:

- Are a resource used to apply consistency in the UM decisions
- Used in the UM decision shall be provided, upon request, to the provider or member

The medical review criteria stated below are updated and approved at least annually by the Medical Director, Medical Advisory Committee and Quality Improvement Committee. Appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts being reviewed have an opportunity to give advice or comment on development or adoption of Utilization Management criteria and on instructions for applying the criteria.

WellCare is responsible for:

- Requiring consistent application of review criteria for authorization decisions; and
- Consulting with the requesting provider when appropriate

One or more of the following criteria are utilized when services are requested that require utilization review:

WellCare’s Coverage and Referral Guidelines	Annually
<u>Criteria</u>	<u>Updated</u>
InterQual Criteria™	Annually
Ingenix Complete Guide to Medicare Coverage Issues	Quarterly
Hayes, Inc. Online™ (Medical Technology)	Ongoing
Medicare Carrier and Intermediary Coverage Decisions	Ongoing
Medicare National Coverage Decisions	Ongoing
Federal Statutes, Laws and Regulations	Ongoing

When applying criteria to members with more complicated conditions, WellCare will consider the following factors when applying criteria to a given individual (member):

- Age;
- Co-morbidities;
- Complications;
- Progress of treatment;
- Psychological situation;
- Home environment, when applicable

WellCare will also consider characteristics of the local delivery system available for specific members, such as:

- Availability of Skilled Nursing Facilities, sub-acute care facilities or home care in WellCare’s service area to support the member after hospital discharge

- Coverage of benefits for Skilled Nursing Facilities, sub-acute care facilities or home care when needed
- Local hospitals' ability to provide all recommended services within the estimated length of stay

When WellCare's standard utilization management guidelines and criteria do not apply due to individual patient (member) factors and the available resources of the local delivery system, the Health Services staff (Review Nurse, Case Manager) will conduct individual case conferences to determine the most appropriate alternative service for that member. The Medical Director may also utilize his/her clinical judgment in completing the service authorization request.

All new medical technology or questionable experimental procedures will require review by the Medical Director prior to approval to establish guidelines where applicable.

Organization Determinations

For all organization determinations, providers may contact WellCare by mail, phone, fax, or Web.

WellCare requires prior authorization and/or pre-certification for:

- All non-emergent and non-urgent inpatient admissions except for normal newborn deliveries;
- All non-emergent or non-urgent, out-of network services (except out-of-area renal dialysis);
- Service requests identified in the Medicare Authorization Guidelines that are maintained within the Health Services Department. Refer to your state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

The processing of requests for initial and continuation of services, WellCare has in place an appropriate mechanism to ensure consistent application of review criteria for authorization reviews, which include:

- Medical Necessity - approved medical review criteria will be referenced and applied
- Inter-rater reliability (IRR) - a process that evaluates the consistency of decisions made by licensed staff when making authorization decisions and ensures the consistent application of medical review criteria
- Consultation with the requesting provider when appropriate

Standard Organization Determination – An organization determination will be made as expeditiously as the member's health condition requires, but no later than fourteen (14) calendar days after WellCare receives the request for service. An extension may be granted for an additional fourteen (14) calendar days if the member requests an extension, or if WellCare justifies a need for additional information and documents how the delay is in the interest of the member.

Expedited Organization Determination – A member or any provider may request WellCare expedite an organization determination when the member or his/her provider believes that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The request will be made as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receiving the member's request. An extension

may be granted for an additional fourteen (14) calendar days if the member requests an extension, or if WellCare justifies a need for additional information and documents how the delay is in the interest of the member.

WellCare's organization determination system provides authorization numbers, effective dates for the authorization, and specifies the services being authorized. The requesting provider will be notified verbally via telephone or via fax of the authorization.

In the event of an adverse determination, WellCare will notify the member and the member's representative (if appropriate) in writing and provide written notice to the provider. Written notification to providers will include the Utilization Management Department's contact information to allow providers the opportunity to discuss the adverse determination decision. The provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Health Services' Utilization Management Department. The member may request a copy of the criteria used for a specific determination of medical necessity by contacting the Customer Service Department.

Reconsideration Requests

WellCare provides an opportunity for the attending physician/ordering provider to request a discussion of an adverse determination within three (3) business days of the decision. The requesting provider will have the opportunity to discuss the decision with the clinical peer reviewer making the denial determination or with a different clinical peer if the original reviewer cannot be available within one (1) business day of the provider request. WellCare will respond to the request within one (1) business day.

Emergency Services

Emergency Services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

It is WellCare's policy that emergency services are covered:

- Regardless of whether services are obtained within or outside the network of providers available;
- Regardless of whether there is prior authorization for the services. In addition:
 - No materials furnished to members (including wallet card instructions) may contain instructions to seek prior authorization for emergency services, and members must be informed of their right to call 911.
 - No materials furnished to providers, including contracts, may contain instructions to providers to seek prior authorization before the member has been stabilized.
- In accordance with a prudent layperson's definition of "emergency medical condition" regardless of the final medical diagnosis;
- WellCare is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, WellCare is not responsible for any costs, such as a biopsy associated with treatment of skin lesions performed by the attending physician who is treating a fracture; and
- Whenever a WellCare provider or other WellCare representative instructs a member to seek emergency services within or outside the member's WellCare plan coverage.

Transition of Care

If a new member has an existing relationship with a provider who is not part of WellCare's provider network, WellCare shall permit the member to continue an ongoing course of treatment by the non-participating provider during a transitional period.

WellCare will honor any written documentation of Prior Authorization of ongoing Covered Services for a period of thirty (30) calendar days (Hawaii: 90 calendar days) after the effective date of enrollment.

For all members, written documentation of Prior Authorization of ongoing services includes the following, provided that the services were prearranged prior to enrollment with WellCare:

- Prior existing orders;
- Provider appointments, e.g., dental appointments, surgeries, etc.;
- Prescriptions (including prescriptions at non-participating pharmacies).

WellCare cannot delay service authorization if written documentation is not available in a timely manner. Contact the Claims Department for claims payment or claims resolution issues and Provider Relations for rate negotiations.

Members who are inpatient at the time of disenrollment from WellCare will be covered by WellCare throughout the acute inpatient stay, however, WellCare will not be responsible for any discharge needs the member may have.

WellCare will take immediate action to address any identified urgent medical needs.

Continued Care with a Terminated Provider

When a provider terminates or is terminated without cause, WellCare will allow the members in active treatment to continue either through the completion of their condition (up to ninety (90) calendar days) or until the member selects a new provider.

When an Obstetrician terminates without cause, WellCare will allow the pregnant member, regardless of trimester, to continue care until the member's post partum visit is completed.

WellCare will inform the provider that care provided after termination shall continue under the same terms, conditions and payment arrangements as they existed in the terminated contract.

If a provider is terminated for cause, WellCare will direct the member immediately to another participating provider for continued services and treatment.

Continuity of Care

WellCare will establish, maintain and monitor a panel of primary care providers (PCPs) from which the member may select a personal PCP. All members may select and/or change their PCP to another participating WellCare Medicare PCP without interference. WellCare requires members to obtain a referral before receiving specialist services and has a mechanism for assigning primary care providers to members who do not select a PCP. WellCare will also:

- Provide or arrange for necessary specialist care and in particular, give women members the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. WellCare will arrange for specialty care outside of the WellCare's provider network when

network providers are unavailable or inadequate to meet a member's medical needs;

- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. WellCare utilizes the provision of translator services and interpreter services;
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies and utilization management that allow for individual medical necessity determinations;
- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services; and
- Have in effect procedures that:
 - Establish and implement a treatment plan that is appropriate;;
 - Include an adequate number of direct access visits to specialists;;
 - Are time-specific and updated periodically;
 - Facilitate coordination among providers; and
 - Considers the member's input.

Second Opinion

WellCare will provide the member the right to a second surgical/medical opinion in any instance when the member disagrees with his/her provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness. The second surgical/medical opinion, if requested, is to be provided by a provider chosen by the member who may select:

- A provider that is participating with WellCare; or
- A non-participating provider located in the same geographical service area of WellCare, if a participating provider is not available.

If WellCare's network is unable to provide necessary services to a particular member, WellCare must adequately and timely cover these services out-of-network for the member, for as long as WellCare is unable to provide them. WellCare will be financially responsible for a second surgical/medical opinion.

Member must inform their PCP of their desire for a second surgical /medical opinion. If a participating Wellcare provider is selected, the PCP will issue a script or a referral to the member for the visit. If a non-participating provider is required, the PCP will contact WellCare for authorization.

Any tests that are deemed necessary as a result of the second surgical/medical opinion will be conducted by participating WellCare providers. The PCP will review the second surgical/medical opinion and develop a treatment plan for the member. If the PCP disagrees with the second surgical/medical opinion request for services, the PCP must still submit the request for services to WellCare for an organization determination on the recommendation.

The member may file an appeal if WellCare denies the second surgical/medical opinion provider's request for services. The member may file a grievance if the member wishes to follow the recommendation of the second opinion provider and the PCP does not forward the request for services to WellCare.

Medicare QIO Review Process of SNF/HHA/CORF Terminations

WellCare will ensure members receive written notification of termination of service from providers no later than two (2) calendar days before the proposed end of service for Skilled Nursing Facilities (SNF), Home Health Agencies (HHA) and Comprehensive Outpatient Rehabilitation Facilities (CORFs). The standard Notice of Medicare Non-Coverage letter required by CMS will be issued. This letter includes the date coverage of service ends and the process to request an expedited appeal with the appropriate Quality Improvement Organization (QIO). Upon notification by the QIO that a member has requested an appeal, WellCare will issue a Detailed Explanation of Non-Coverage (DENC) which indicates why services are either no longer reasonable or necessary or are no longer covered.

The standardized Notice of Medicare Non-Coverage (NOMNC) of Skilled Nursing, Home Health and Comprehensive Rehabilitation services will be given to the member or, if appropriate, to the member's representative, by the provider of service no later than two (2) calendar days before the proposed end of services. If the member's services are expected to be fewer than two (2) calendar days in duration, the provider should notify the member or, if appropriate, the member's representative, at time of admission. If, in a non-institutional setting, the span of time between services exceeds two (2) calendar days, the notice should be given no later than two (2) services prior to termination of the service.

WellCare is financially liable for continued services until two (2) calendar days after the member receives valid notice. A member may waive continuation of services if s/he agrees with being discharged sooner than two (2) calendar days after receiving the notice.

Members who desire a fast-track appeal must submit a request for appeal to the QIO, in writing or by telephone, by noon (12 p.m.) of the first day after the day of delivery of the termination notice or, where a member receives the NOMNC more than two (2) calendar days prior to the date coverage is expected to end, by noon (12 p.m.) of the day before coverage ends. Upon notification by the QIO that a member has requested an appeal, WellCare will issue a Detailed Explanation of Non-Coverage (DENC) which indicates why services are either no longer reasonable or necessary or are no longer covered.

Coverage of provider services continues until the date and time designated on the termination notice, unless the member appeals and the QIO reverses WellCare's decision.

A member who fails to request an immediate fast-track QIO review in accordance with these requirements may still file a request for an expedited reconsideration with WellCare.

Notification of Hospital Discharge Appeal Rights

Prior to discharging a member or lowering the level of care within a hospital setting, WellCare will secure concurrence from the provider responsible for the member's inpatient care.

WellCare will ensure members receive a valid written notification of termination of inpatient services from the facility according to the guidelines set by Medicare. Hospitals must issue the Important Message (IM) within two (2) calendar days of admission, obtain signature of patient or the signature of their authorized representative, and provide a

signed “follow up” copy to the patient as far in advance of discharge as possible, but not more than two (2) calendar days before discharge. This letter will include the process to request an immediate review with the appropriate QIO.

Members who desire an immediate review must submit a request to the QIO, in writing or by telephone, by midnight (12 a.m.) of the day of discharge. The request must be submitted before the member leaves the hospital.

If the member fails to make a timely request to the QIO s/he may request an expedited reconsideration by WellCare.

Upon notification by the QIO that a member has requested an immediate review, WellCare will contact the facility, request all relevant medical records, a copy of the executed IM, and evaluate for validity. If after review, WellCare concurs that the discharge is warranted, WellCare will issue a Detailed Notice of Discharge providing a detailed reason why services are either no longer reasonable, necessary or are no longer covered..

Coverage of inpatient services continues until the date and time designated on the Detailed Notice of Discharge, unless the member requests an immediate QIO review. Liability for further inpatient hospital services depends on the QIO decision.

If the QIO determines that the member did not receive valid notice, coverage of inpatient services by WellCare continues until at least two (2) calendar days after valid notice has been received. Continuation of coverage is not required if the QIO determines that the coverage could pose a threat to the member’s health or safety.

The burden of proof lies with WellCare to demonstrate that discharge is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies. To meet this burden, WellCare must supply any and all information that the QIO requires to sustain WellCare’s decision.

WellCare is financially responsible for coverage of services, regardless of whether it has delegated responsibility for authorizing coverage or termination decisions to its providers.

If the QIO reverses WellCare’s termination decision, WellCare must provide the member with a new notice when the hospital or WellCare once again determines that the member no longer requires acute inpatient hospital care.

Availability of Utilization Management Staff

WellCare provides medical and support staff resources, including a Medical Director, to process requests and provide information for the routine or urgent authorization/pre-certification of services, utilization management functions, provider questions, comments or inquiries, twenty-four (24) hours per day, seven (7) days per week.

Providers have the option of contacting the Health Services Department by phone twenty-four (24) hours a day, seven (7) days a week including holidays. For after hours, or for any issues or requests requiring immediate clinical review or information, there is an on-call Nurse Manager and Medical Director available twenty-four (24) hours a day, seven (7) days a week including holidays. For more information on contacting the Health Services Department, refer to the state-specific Quick Reference Guide which

Case Management Program

Overview

WellCare offers comprehensive Case Management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. WellCare trusts providers will help coordinate the placement and cost-effective treatment of patients who are eligible for WellCare Case Management Programs. For specific information on Case Management programs for Dual Eligible members, or Model of Care (MOC), see *Section X. Dual Eligible Members*.

WellCare's Case Management teams are lead by specially trained Registered Nurse (RN) Case Managers who 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 care plan.

The Case Management teams work collaboratively with PCPs to coordinate care for the member and expedite access to care and needed services.

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

The Case Management process illustrates the formation of one seamless Case Management Program and begins with member identification, and follows the member until discharge from the Program. Members may be identified for Case Management through numerous ways, including (a) a referral from a member's primary care physician; (b) self-referral; (c) referral from a family member, (d) after completing a Health Risk Assessment (HRA; and (e) data mining for members with high utilization). WellCare's philosophy is that the Case Management Program is an integral management tool in providing a continuum of care for WellCare members. Key elements of the Case Management process include:

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

care for members through the coordination of care among physicians and other providers.

Members commonly identified for WellCare's Case Management Program include:

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

The Case Managers work closely with the and provider on when to Members discharge the member from Case Management services. Reasons for discharge from Case Management include: member meeting primary care plan goals, member declining additional case management services, disenrollment from health plan, and inability to reach member.

Provider Access to Case Management

Refer to *Access to Case and Disease Management Programs* in the Disease Management section below.

Disease Management Program

Overview

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

The Disease Management Program includes the following conditions:

- Asthma - adult and pediatric;
- Coronary artery disease (CAD);
- Congestive heart failure (CHF);
- Chronic obstructive pulmonary disease (COPD);
- Diabetes - adult and pediatric;
- HIV; and
- Hypertension.

Candidates for Disease Management

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

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

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

Access to Case and Disease Management Programs

If you would like to refer a WellCare member as a potential candidate to the Case Management Programs or the Disease Management Program, or would like more information about one of the programs, you may call the WellCare Case Management Referral Line or complete and fax the Care Management Referral Form which can be found on WellCare's website at http://www.wellcare.com/Provider/Medicare_FormsandDocuments

For more information on the Case Management Referral Line, refer to the state-specific Quick Reference Guide which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

VI. Quality Improvement

Overview

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

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

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures, and/or medical record audits.

Medical Records

Medical records should be comprehensive reflecting all aspects of care for each member. Records are to be maintained in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

Confidentiality of member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Records remaining under the care, custody, and control of the physician or health care provider shall be maintained for a minimum of ten (10) years from the date of when the last professional service was provided. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

Provider Participation in the Quality Improvement Program

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

Information regarding the QI Program, available upon request, includes a description of the QI Program and a report on progress in meeting goals. WellCare evaluates the effectiveness of the QI Program on an annual basis. This report is summarized and is available as a written document.

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

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

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

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

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

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the

member's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from participating providers and the Quality Improvement Committee. Activities include distribution of information, encouragement to utilize screening tools and ongoing monitoring and measuring of outcomes. While WellCare can and does implement activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.

Clinical Practice Guidelines

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

HEDIS®

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

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

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

Web Resources

WellCare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the WellCare website. Please check the website frequently for the latest news via web banner and updated documents.

VII. Appeals and Grievances

Appeals Process

Provider

Medicare Provider on Behalf of Self -Appeals Process

A provider may request a standard reconsideration on his or her own behalf by mailing or faxing a letter of appeal and/or an appeal form with supporting documentation such as medical records to WellCare. Appeal forms are located on WellCare's website at http://www.wellcare.com/Provider/Medicare_FormsandDocuments

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

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

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

Reversal of Denial

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

The provider may file a claim for payment related to the appeal, if they have not already done so. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. WellCare will ensure that claims are processed and comply with the federal and state requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.

Affirmation of Denial

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

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

Member

For a member appeal, the member, member's representative, or a provider acting on behalf of the member and with the member's written consent, may file an appeal. Providers do not have appeal rights through the member appeals process. However, providers have the ability to file an authorization or claim-related appeal (dispute) on their own behalf.

If the member wishes to use a representative, then s/he must complete an Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on WellCare's website at http://www.wellcare.com/Provider/Medicare_FormsandDocuments. Prior to the service(s) being rendered, providers may appeal on behalf of the member if they have the member's written consent in their records.

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

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

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

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state.

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

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

- Expedited Request: **72 hours**
- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **30 or 60 calendar days as applicable**

A written description or summary of the Policy and Procedure is available upon request to any member, provider, or facility rendering service.

Expedited Appeals Process

To request an expedited reconsideration, a member or a provider (regardless of whether the provider is affiliated with WellCare) must submit an oral or written request directly to WellCare. A request to expedite a reconsideration of a determination will be considered

in situations where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision to the member. In light of the short time frame for deciding expedited reconsiderations, a provider does not need to be an authorized representative to request an expedited reconsideration on behalf of the member. However, the provider must have the member's consent on file.

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

Denial of an Expedited Request

WellCare will provide the member with prompt oral notification within twenty-four (24) hours regarding the denial of an expedited reconsideration and the member's rights, and will subsequently mail to the member within three (3) calendar days of the oral notification, a written letter that:

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

Resolution of an Expedited Appeal

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

Reversal of Denial of an Expedited Appeal

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

Affirmation of Denial of an Expedited Appeal

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

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has seventy-two (72) hours from receipt of the case to issue a final determination;
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE;

Once a final determination has been made, the IRE will notify the member and WellCare. In the event the IRE agrees with WellCare, the IRE will provide the member further appeal rights. If the IRE overturns the denial, the IRE notifies the member or representative in writing of the decision.

Standard Pre-Service Appeals Process – Member or Member’s Representative

A member, provider on behalf of a member, or a member’s representative may file an appeal request either verbally or in writing within sixty (60) calendar days of the date of the adverse organization determination.

If an appeal is filed verbally through Customer Service, the request must be followed up with a written, signed appeal to WellCare. WellCare’s reconsideration of the appeal begins with the receipt of the signed appeal request.

If the member request for reconsideration is submitted after sixty (60) calendar days, then good cause must be shown in order for WellCare to accept the late request.

Examples of good cause include but are not limited to:

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

Reversal of Denial of a Standard Pre-Service Appeal

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

Affirmation of Denial of a Standard Pre-Service Appeal

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

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has thirty (30) days from receipt of the case to issue a final determination.
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and WellCare. In the event the IRE agrees with WellCare, the IRE will provide the member further appeal rights.

If the IRE overturns the denial, the IRE notifies the member or representative in writing of the decision. WellCare will also notify the member, member’s representative, and provider on behalf of the member in writing that the services are approved along with an authorization number within fourteen (14) calendar days from receipt of the IRE’s determination.

Standard Retrospective Appeals Process - Medicare Provider on Behalf of Self

A provider may request a standard retrospective reconsideration on his/her own behalf by mailing or faxing a letter of appeal and/or an appeal form with supporting documentation such as medical records to WellCare. Appeal forms may be found on WellCare’s website at http://www.wellcare.com/Provider/Medicare_FormsandDocuments

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

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

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

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

Reversal of Denial of a Medicare Provider on Behalf of Self Appeal

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

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

Affirmation of Denial of a Medicare Provider on Behalf of Self Appeal

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

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

Standard Retrospective Appeals Process – Member or Member’s Representative

A member or a member’s representative may file a standard retrospective appeal request either verbally or in writing within sixty (60) days of the date of the adverse organization determination.

If an appeal is filed verbally through Customer Service, the request must be followed up with a written, signed appeal to WellCare. For verbal filings, the time frames for resolution begin on the date the verbal filing was received.

Reversal of Denial of a Standard Retrospective Appeal

If, upon reconsideration, WellCare overturns its adverse organization determination denying a member's request for payment, then WellCare will issue its reconsidered determination and send payment for the service. This payment will be mailed no later than sixty (60) calendar days from the date it received the request of a valid complete standard reconsideration.

Affirmation of Denial of a Standard Retrospective Appeal

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

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has sixty (60) days from receipt of the case to issue a final determination.
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and WellCare. In the event the IRE agrees with WellCare the IRE will provide the member further appeal rights.

If the IRE overturns the denial, the IRE notifies the member or representative in writing of the decision. WellCare will also notify the member, member's representative, and provider on behalf of the member in writing that the services are approved and payment for the service will be issued within thirty (30) calendar days from receipt of the IRE's determination.

Appeal Levels

There are five (5) levels of appeals available to Medicare beneficiaries enrolled in Medicare Advantage plans offered by WellCare after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of adverse organization determination by WellCare;
2. Reconsideration of adverse organization determination by the Independent Review Entity (IRE);
3. Hearing by an Administrative Law Judge (ALJ), if the appropriate threshold requirements set forth in § 100.2 has been met;
4. Medicare Appeals Council (MAC) Review; and
5. Judicial Review, if the appropriate threshold requirements set has been met.

WellCare gives members reasonable assistance in completing forms and other procedural steps for an appeal, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability.

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

Grievance Process

Provider

Medicare providers are not able to file a grievance per CMS guidance.

Member

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

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

A written description or summary of the Policy and Procedure is available upon request to any member, provider, or facility rendering service.

A member or a member's representative may file a standard grievance request either verbally or in writing within sixty (60) calendar days of the date of the incident or when the member was made aware of the incident.

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

Grievance Resolution

Expedited

A member or member's representative may request an expedited grievance if WellCare makes the decision not to expedite an organizational determination, expedite an appeal, or invoke an extension to a review. An expedited grievance will be responded to within twenty-four (24) hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review time frame or extend a review time frame does not jeopardize the member's health.

WellCare will contact the member or the member's representative, via telephone with the determination and will mail the resolution letter to the member or the member's representative within three (3) business days after the determination is made. The resolution will also be documented in the member's record.

Standard

A member or member's representative shall be notified of the decision as expeditiously as the case requires, based on the member's health status, but no later than thirty (30) calendar days after the date WellCare receives the oral or written grievance, consistent with applicable federal law. Unless an extension is elected, WellCare will send a closure letter upon completion of the member's grievance.

Up to a fourteen (14) calendar day extension may be requested by the member or the member's representative. WellCare may also initiate an extension if it can justify the need for additional information and if extension is in the member's best interest. In all cases, extensions must be well-documented. WellCare will provide the member or the member's representative prompt written notification regarding WellCare's plan to take up to a fourteen (14) calendar day extension on a grievance case.

The Grievance Department will inform the member of the determination of the grievance as follows:

- All grievances submitted, either verbally or in writing, will be responded to in writing; and
- All grievances related to quality of care will include a description of the member's right to file a written complaint with the Quality Improvement Organization (QIO). For any complaint submitted to a QIO, WellCare will cooperate with the QIO in resolving the complaint.

WellCare will provide all members with written information about the grievance procedures/process available to them, as well as the complaint processes. WellCare will provide written information to members and/or their appointed representative(s) about the grievance procedure at: (a) initial enrollment; (b) upon involuntary disenrollment initiated by WellCare; (c) upon the denial of a member's request for an expedited review of a determination or appeal; (d) upon the member's request and; (e) annually thereafter. WellCare will provide written information to members and/or their appointed representatives about the QIO process at initial enrollment and annually thereafter.

The facts surrounding a complaint will determine whether the complaint is for coverage determination, organization determination or an appeal and will be routed appropriately for review and resolution.

VIII. Delegated Entities

Overview

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

Compliance:

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

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

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

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

- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs;
- Ensure that WellCare has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and WellCare, reporting requirements, and delegated activities in a clear and understandable manner;
- Ensure that the appropriate WellCare associates have properly evaluated the entity's ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity's performance at least annually, including monitoring to ensure quality of care and quality of service is not compromised by financial incentives;
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate.

IX. Compliance

WellCare Compliance Program

Overview

WellCare has a corporate ethics and compliance program, as may be amended from time to time, which includes information regarding WellCare's policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by WellCare, WellCare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All providers, including provider employees and provider sub-contractors and their employees, are required to comply with WellCare compliance program requirements, including:

- WellCare's compliance training requirements including but not limited to:
 - Compliance Plan Training
 - To ensure policies, procedures and related compliance concerns are clearly understood and followed;
 - To provide a mechanism to report suspected violations and disciplinary actions to address violations.
 - HIPAA Privacy & Security Training
 - To encompass privacy and security requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
 - Must include, but not limited to:
 - Uses and Disclosures of PHI;
 - Member Rights; and
 - Physical and technical safeguards.
 - Fraud, Waste and Abuse (“FWA”) Training
 - Must include, but not limited to:
 - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.);

- Obligations of the provider including provider employees and provider sub-contractors and their employees to have appropriate policies and procedures to address fraud, waste, and abuse;
- Process for reporting suspected fraud, waste and abuse;
- Protections for employees and subcontractors who report suspected fraud, waste and abuse;
- Types of fraud, waste, and abuse that can occur..
- Cultural Competency Training
 - Develop programs to educate and identify the diverse cultural and linguistic needs of the members they serve.
- Disaster Recovery and Business Continuity
 - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short term or long term interruption of services.

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

Marketing Medicare Advantage Plans

Medicare Advantage (MA) plan marketing is regulated by the Centers for Medicare and Medicaid Services ("CMS"). Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V (replacing regulations formerly at 42 CFR 422.80), and the CMS Managed Care Manual, Chapter 3, Medicare Marketing Guidelines for MA Plans, MA-PDs, PDPs and 1876 Cost Plans ("Marketing Guidelines"), including without limitation materials governing "Provider Based Activities" in section 70.8.3.

Providers must adhere to all applicable laws, regulations and CMS guidelines regarding MA plan marketing, including without limitation 42 CFR Part 422, Subpart V and the Marketing Guidelines.

CMS holds plan sponsors such as WellCare responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Providers are not authorized to engage in any marketing activity on behalf of WellCare without the express written consent of an authorized WellCare representative, and then only in strict accordance with such consent.

Code of Conduct and Business Ethics

Overview

WellCare has a Code of Conduct and Business Ethics policy, found at <http://www.wellcare.com/AboutUs/default> with which all Providers should familiarize themselves. Participating Providers and other contractors of WellCare are encouraged to report compliance concerns and any suspected or actual misconduct.

Fraud, Waste, and Abuse

WellCare is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. WellCare has developed an aggressive, proactive fraud and abuse

program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and WellCare vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

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

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

Providers, including provider employees and/or provider sub-contractors, must report to WellCare any suspected fraud, waste or abuse, misconduct or criminal acts by WellCare, or any provider, including provider employees and/or provider sub-contractors, or by WellCare members. Reports may be made anonymously through the WellCare fraud hotline at (866) 364-1350. Details of the corporate ethics and compliance program, may be found on WellCare's website at <http://www.wellcare.com/AboutUs/default>

Site Inspection Evaluations

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

- Office site criteria
 - Physical accessibility;
 - Physical appearance;
 - Adequacy of waiting room and examination room space.
- Medical / treatment record keeping criteria.

SIE's are conducted for:

- Unaccredited Facilities;
- State-specific initial credentialing requirements;
- State-specific re-credentialing requirements;
- When complaint/grievance quality criteria thresholds are met.

In those states where initial SIE's are not a requirement for credentialing, ongoing monitoring of member complaints is performed on a monthly basis. SIE's are conducted for those sites where complaints regarding the site are received. . In addition, SIE's may be performed for any quality of care concern if the severity of the issue is determined to warrant an onsite review.

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 provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members' medical records and other protected health information (PHI 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 provider practice is required to provide members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Some examples of confidential information include:

- Medical records;
- Communication between a member and a 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;
- 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 informs the patient or member of their member rights under HIPAA and how the provider and/or WellCare may use or disclose the members' PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or member.

Disclosure of Information

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

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

Cultural Competency Program and Plan

Overview

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

The objectives of the Cultural Competency program are to:

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

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

The components of WellCare's Cultural Competency program include:

Data Analysis

- Analysis of claims and encounter data to identify the health care needs of the population;
- Collection of member data on race, ethnicity and language spoken.

Community-based Support

- Outreach to community-based organizations which support minorities and the disabled in ensuring that the existing resources for members are being utilized to their full potential.

Diversity

- Non-discriminating – WellCare providers may not discriminate with regard to race, religion or ethnic background when hiring associates;

- Recruiting – Providers are expected to recruit diverse talented associates in all levels of management;
- Multilingual – WellCare recruits bilingual associates for areas that have direct contact with members to meet the needs identified, and encourages providers to do the same.

Diversity of Provider Network

- Providers are inventoried for their language abilities and this information is made available in the Provider Directory so that members can choose a provider that speaks their primary language;
- Providers are recruited to ensure a diverse selection of providers to care for the population served.

Linguistic Services

- Providers will identify members that have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance;
- Members may receive interpreter services at no cost when necessary to access covered services through a vendor, as arranged by the Customer Service Department;
- Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by WellCare's Customer Service Department;
- Written materials are available for members in large print format, and certain non-English languages, prevalent in WellCare's service areas.

Electronic Media

- Telephone system adaptations – members have access to the TTY/TDD line for hearing impaired services. The Customer Service Department is responsible for any necessary follow-up phone calls to the member. The toll-free TTY/TDD number can be found on the member identification card.

Provider Education

- The Cultural Competency Program provides a Cultural Competency Checklist to assess the provider office's Cultural Competency;
- For more information on the Cultural Competency Program, refer to National Center for Cultural Competency website at <http://www11.georgetown.edu/research/gucchd/nccc/index.html>
- Providers must adhere to the Cultural Competency program as set forth above.

Cultural Competency Survey

You may access the Cultural Competency Survey on WellCare's Web site at: http://www.wellcare.com/Provider/Medicare_FormsandDocuments

¹ *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, U.S. Department of Health and Human Services, Office of Minority Health, December 2000.

² *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans*, Centers for Medicare and Medicaid Services and Agency for Healthcare Research and Quality, 2003

³ Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected. Department of Justice regulations (28 CFR Section 42.405(d)(1)) state: "Where a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program ... needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

X. Dual Eligible Members

Overview

Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit are often referred to as “dual eligibles.” These benefits are sometimes referred to as Medicare Savings Programs (MSPs). Dual eligibles are eligible for some form of Medicaid benefit, whether that Medicaid coverage is limited to certain costs, such as Medicare premiums or the full benefits covered under the state Medicaid plan.

Types of Dual Eligible Members

States provide Medical Savings Programs (MSPs) which provide medical cost assistance to dual eligible members, and depending on the level of Medicaid eligibility, may provide coverage of Medicare Parts A and B cost-sharing member expenses. There are multiple MSP categories and the categories are based upon the beneficiary’s income and asset levels as well as “medically needy” status. Members learn of their MSP from an award letter they receive from the Social Security Administration (SSA) and possibly through notification from the state Medicaid agency.

For full definitions of the current categories of Dual Eligible members contained herein, see the *Definitions* section of this manual.

See the chart below for the different categories of Dual Eligible members:

Medicare Savings Program (MSP) Assistance	FFS Part A Premium Covered?	FFS Part B Premium Covered?	Part A & B Cost- Sharing Covered?	Full Medicaid Benefits Provided?
Qualified Medicare Beneficiary (QMB)	YES	YES	YES	NO
QMB Plus (QMB+)	YES	YES	YES	YES
Specified Low-Income Medicare Beneficiary (SLMB)	NO	YES	NO	NO
SLMB Plus (SLMB+)	NO	YES	YES	YES
Qualifying Individual (QI)	NO	YES	NO	NO
Qualified Disabled Working Individual (QDWI)	YES	NO	NO	NO
Full Benefit Dual Eligibles	YES	YES	YES	YES

QMB, QMB+, SLMB+ and FBDE beneficiaries are considered “zero cost-share” dual eligible members since they pay no Part A or Part B cost-share.

Payments and Billing

For all zero cost-share dual eligible members (QMB, QMB+, SLMB+ and FBDE), Medicaid is responsible for deductible, coinsurance, and co-pay amounts for Medicare Parts A and B covered services. Providers may not “balance bill” these members, which means providers may not bill these members for either the balance of the Medicare rate or the provider’s customary charges for Part A or B services. The member is protected from liability for Part A and B charges, even when the amounts the provider receives from Medicare and Medicaid are less than the Medicare rate or less than the provider’s customary charges. Providers who bill these members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

Providers agree to accept WellCare’s payment as payment in full or will bill the appropriate state source. If WellCare has assumed the state’s financial responsibility under an agreement between WellCare and the state, WellCare shall be considered the “appropriate state source”

Referral of Dual Eligible Members

When a participating provider refers a dual eligible member to another provider for services, the provider should make every attempt to refer the dual eligible member to a provider who participates with both WellCare and the state Medicaid agency. Providers who participate with the state Medicaid plan can be located at the applicable state’s Medicaid website.

Dual Eligible Members Who Lose Medicaid Eligibility/Status

Many dual eligible members are members of Dual Special Needs Plans (DSNPs). For more information on DSNPs, refer to *Section I: Overview*.

CMS requires DSPN plans to provide a member a period of at least thirty (30) days and up to six (6) months to allow those dual eligible members who have lost Medicaid eligibility or had a change in status an opportunity to regain their eligibility. This period is called the “Deeming Period”. A change in status relates to the dual eligible member either losing Medicaid eligibility or has falling below the plan required Medicaid Eligibility level.

During the Deeming Period, WellCare pays 100% of the Medicare allowable to protect its members from cost-sharing. Providers must accept WellCare’s payment as payment in full and may not balance bill the member.

Dual Eligible State Specific Contract Obligations

MISSOURI
Provider agrees that in order to bill MO HealthNet for its financial obligations, the provider shall be enrolled with MO HealthNet as a Medicaid provider.
NEW YORK (LIBERTY AND ADVOCATE COMPLETE PRODUCTS)
Provider must accept payment received from WellCare for services included in the Combined Medicare Advantage and Medicaid Advantage benefit package as payment in full for services provided to enrollees. In the event WellCare does not reimburse for a service, providers may not seek payment from State Department of Health, Local Departments of Social Services, members, or member representatives.
OHIO
Providers may access the Ohio Administrative code at the following website: http://emanuals.odjfs.state.oh.us/emanuals/GetDocument.do?nodeId=%23node-id(297)&docId=Document(storage%3DREPOSITORY%2CdocID%3D%23node-id(730024))&locSource=input&docLoc=%24REP_ROOT%24%23node-id(730024)&version=8.0.0 and, the Ohio Medicaid Handbook at the following website: http://emanuals.odjfs.state.oh.us/emanuals/GetTocDescendants.do?nodeId=%23node-id(629)&maxChildrenInLevel=100&version=8.0.0

TEXAS
Providers may access a list of WellCare's benefit offerings at the following website: http://www.wellcare.com/WCAssets/corporate/assets/M0012_NA010448_WCM_SOB_ENG_FINAL_56.pdf . Information concerning Medicaid provider participation is available on WellCare's website at: http://www.wellcare.com/provider/resources , and the state's website at: http://www.tmhp.com/OPL/providerManager/AdvSearch.aspx .
LOUISIANA
WellCare of Louisiana, Inc. providers may access a list of WellCare's benefit offerings at the following website: http://www.wellcare.com/medicare_sb/louisiana . Information concerning Medicaid provider participation is available on WellCare's website: http://www.wellcare.com/medicare_eoc/louisiana , and the state's website: http://www.lamedicaid.com/provweb1/default.htm .
GEORGIA
WellCare of Georgia, Inc. providers may access a list of WellCare's benefit offerings at the following website: http://www.wellcare.com/medicare_sb/georgia . Information concerning Medicaid provider participation is available on WellCare's website: http://www.wellcare.com/medicare_eoc/georgia and the state's website: http://www.georgia.gov/00/channel_title/0,2094,31446711_31944147,00.html

DSNP Case Management Program

Overview

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was approved by Congress and became law in July of 2008. MIPPA mandates a health risk assessment, care plan, interdisciplinary care team for members and evaluation of care effectiveness by the health plan.

WellCare's Model of Care (MOC) is tailored specifically to the dual eligible members in an effort to meet the populations' social, medical, and behavioral needs in a member centric fashion.

Health Risk Assessment: Conducted by WellCare: WellCare's Case Management MOC begins with the Health Risk Assessment (HRA). The HRA assesses member risk in the following areas: functional, psychosocial, and medical. Once completed, the HRA is stratified and reviewed by a DSNP Registered Nurse (RN) Case Manager. The stratification of the HRA is an indicator of the needs of the member and is verified with the Comprehensive Medical Assessment. WellCare utilizes four (4) levels of stratification starting with level 1 (low risk) and going to level 4 (high risk). The RN Case Manager outreaches to the dual eligible member and begins the Case Management process.

Comprehensive Medical Assessment: Conducted by WellCare - The RN Case Manager telephonically conducts the Comprehensive Medical Assessment with the dual eligible member and/or caregiver, if appropriate, in order to collect additional social,

medical, and behavioral information to generate a robust *member centric* Individualized Care Plan. The Comprehensive Medical Assessment is based on Clinical Practice Guidelines and allows for the plan of care to be generated utilizing these guidelines.

Individualized Care Plans (ICP): Generated by WellCare - Once the RN Case Manager and the member and/or caregiver complete the comprehensive medical assessment, an ICP is generated that reflects the member's specific problems, short and long-term goals, and interventions. The RN Case Manager and the dual eligible member and/or caregiver, if appropriate, agree on the plan of care and set goals. The ICP generated tracks dates and goal progress. The contact times will vary depending on the stratification of the member and specific goal timeframes. The ICP is shared with all members of the Interdisciplinary Care Team (ICT) for input and updates.

Interdisciplinary Care Team (ICT): WellCare and Providers - The RN Case Manager shares the ICP with all the members of the Interdisciplinary Care Team (ICT) in an effort to inform all those involved in the member's care and ensure that all are aware of the members' goals and current health status. The RN Case Manager communicates and coordinates with the members of the ICT (PCP, Specialists, Social Worker, etc.) to assist the member in navigating the health care system, education, and advocacy. The team provides the basis for meeting the goals of the ICP.

Care Transitions: WellCare and Providers - The RN Case Manager is responsible for coordinating care when members move from one setting to another and facilitates transitions through communication and coordination with member and their usual provider. During this communication with the member, the Case Manager will discuss any changes to the member's health status and any resulting changes to the plan of care. The Case Manager will notify the member's usual provider of the transition and will communicate any transition needs to assist with a smoother transition process.

Provider Required Participation

To meet the intent of the MIPPA legislation, providers are required to participate in the model of care for all DSNP plan members. The expectations for participation are as follows:

- Review the member care plan faxed to you by the Case Manager;
- Update the care plan with any required changes, including any transition needs and return to the Case Manager at the number provided on the care plan;
- Participate in ICT for all DSNP members and give feedback as appropriate. A Case Manager will contact you regarding the date and time of such meetings.

The Case Manager will communicate with the members of the ICT for any updates to the ICP and will be available to assist the dual eligible member to meet the goals of the ICP.

Re-cap of the benefits of the DSNP Case Management Program:

- All Members are outreached for a Health Risk Assessment
- Members are stratified according to the severity of their disease process, functional ability and psychosocial needs.
- Comprehensive Medical Assessment is completed by RN Case Manager and is the basis for the Individualized Care Plan.
- Individualized Care Plan generated by RN Case Manager in collaboration with the member and Care Team.

- Sharing of Individualized Care Plan with Providers for review and comments as needed.
- Continued monitoring, education, coordination of care and member advocacy by RN Case Manager.
- Providers receive Clinical Practice Guidelines based on nationally-recognized evidence-based guidelines.
- Providers receive newsletters that feature articles regarding the latest treatments for patients.

XI. Behavioral Health

Overview

WellCare provides a behavioral health benefit for Medicare plans. For complete information regarding benefits and exclusions, contact WellCare's behavioral health services vendor as referenced in your state-specific Quick Reference Guide which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

WellCare has designated Magellan Behavioral Health to manage WellCare's behavioral health program. You may access Magellan's medical necessity criteria and Clinical Practice Guidelines on Magellan's provider website at www.MagellanHealth.com/provider

Behavioral Health Program

All behavioral health services require prior authorization including services provided by non-participating providers. In the event the member is in need of a referral to a behavioral health provider, contact WellCare's behavioral health services vendor as referenced in your state-specific Quick Reference Guide which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

Continuity and Coordination of Care Between Medical Care and Behavioral Healthcare

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

XII. Pharmacy

Overview

Formulary Management, when properly designed and implemented, promotes rational, clinically appropriate, safe, and cost-effective drug therapy. This encompasses drug selection, drug utilization tools, generic utilization and other methods to ensure best practices.

WellCare's use of Pharmacy Utilization Management Tools, including prior authorization, step therapy, and quantity limits ensures members are given appropriate access to drugs in a timely manner.

To contact the Pharmacy department, please refer to the state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>. For more information on WellCare's benefit plans, visit WellCare's website at <http://www.wellcare.com/medicare/default>

Formulary

Clinical decisions by the Pharmacy and Therapeutics (P&T) Committee, including the addition or deletion of a drug from the formulary, is based on a review of the following:

- The safety and efficacy of the drug;
- The manufacturer, Food and Drug Administration (FDA) approved indications, medically accepted indications (off-label use) as referenced in approved compendia (American Hospital Formulary Service Drug Information (AHFS), DRUGDEX Information System, United States Pharmacopeia-Drug Information (or its successor publications)), mechanism of action, pharmacokinetics, dosage form(s), usual dose, adverse drug reactions, contraindications/warnings and drug interactions;
 - Peer-reviewed medical literature, evidence-based primary literature, secondary literature and tertiary literature, comparative studies and national clinical guidelines, step therapy algorithms and/or protocols based on the national guidelines to ensure appropriate prescribing;
 - Patient compliance considerations;
 - Cost effectiveness and pharmacoeconomic studies of the drug; and
 - Outcomes research data.

WellCare will generally cover the drugs listed in WellCare's formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy, and other WellCare plan rules are followed. The formulary, which may be amended, can be found on the WellCare website at http://www.wellcare.com/medicare/medication_guide

Additions and Exceptions to the Formulary

To request consideration for inclusion of a drug on WellCare's formulary, please write or fax WellCare, explaining the medical justification. Written requests should be addressed to:

WellCare Health Plans Clinical Pharmacy Department
Director of Formulary Services
Pharmacy & Therapeutics Committee
P.O. Box 31401
Tampa, FL 33631-3401

Faxed requests can be sent to the number listed on your state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

To request an exception to the formulary, please refer to the Coverage Determination Request Process outlined in this section below.

Formulary Benefit Management Tools

WellCare has established a Drug Utilization Management Program that includes incentives to reduce costs when medically appropriate and maintains policies and systems to assist in preventing over-utilization and under-utilization of prescribed medications.

Generic Medications

WellCare covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Coverage Limitations

The following is a list of non-covered (i.e., excluded) drugs and/or categories:

- Agents when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose (i.e., morbid obesity));
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes or hair growth;
- Agents when used for the symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
- Nonprescription over-the-counter (OTC) drugs;
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;
- Barbiturates, with the exception of butalbital/codeine combinations;
- Benzodiazepines; and
- Agents when used for the treatment of sexual or erectile dysfunction (ED). ED drugs will meet the definition of a Part D drug when prescribed for medically-accepted indications approved by the FDA other than sexual or erectile dysfunction (such as pulmonary hypertension).

Step Therapy:

Step Therapy programs are developed by the P&T Committee. These programs are designed to provide our members with clinically-sound, cost-effective drug treatment options.

Step Therapy programs encourage the use of select therapies before alternative second line therapies are prescribed. Step Therapy programs follow an extensive review of clinical literature, manufacturer product information and consultation with a team of health care providers to assure a clinically comprehensive program. Part D drugs requiring step therapy are designated by the letters “ST” in the Requirements/Limits column of WellCare’s formulary.

Prior Authorization:

Prior authorization protocols are developed and reviewed annually by the P&T Committee. Prior Authorization protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s)). Part D drugs requiring Prior Authorization are designated by the letters “PA” in the Requirements/Limits column of WellCare’s formulary.

Quantity Limits:

To minimize inappropriate utilization, waste, and stockpiling of drugs, WellCare uses quantity limits to ensure that quantities supplied are consistent with FDA-approved

clinical dosing guidelines. WellCare also utilizes quantity limits to help prevent billing errors. Part D drugs that have quantity limits are designated by the letters “QL” and the quantity permitted, in the Requirements/Limits column of WellCare’s formulary.

Therapeutic Interchange:

Therapeutic interchange is not a Formulary Benefit Management tool which WellCare provides.

Mail Order

Part D drugs that are available through mail order are designated by the letters “MO” in the Requirements/Limits column of WellCare’s formulary. Members who utilize WellCare’s Specialty Pharmacy, Inc. Mail Services Division may be eligible for reduced co-payment amounts. A Member Registration and Prescription Mail order Form can be found on WellCare’s website at http://www.wellcare.com/WCAssets/corporate/assets/Mail_Order_Form_Corporate.pdf

Injectable/Infusion Services

Self-injectable medications, specialty medications and home infusion medications are covered as part of the outpatient pharmacy benefit. Non-formulary injectable medications and those listed on the formulary with a prior authorization will require submission of a Coverage Determination Request form for review. See *Obtaining a Coverage Determination Request* for more information.

Over-the-Counter Medications

Medications available to the member without a prescription are not eligible for coverage under the member’s Medicare Part D benefit.

Member Co-Payments

The co-payment and/or coinsurance are based on the drug tier and the member’s subsidy level. Refer to the member’s state-specific Summary of Benefits for the exact co-pay/coinsurance located on WellCare’s website at: http://www.wellcare.com/medicare_sb/states

Coverage Determination Request Process

The goal of the Coverage Determination request program is to ensure that medication regimens that are high-risk, have a high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA- approved indications.

The Coverage Determination request process is required for:

- Drugs not listed on the formulary;
- Drugs listed on the formulary with a prior authorization (PA);
- Duplication of therapy;
- Prescriptions that exceed the FDA daily or monthly quantity limits (QL);
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician’s office;
- Prescriptions exceeding the permitted quantity limit (QL) noted on the formulary; and
- Drugs that have a step edit (ST) and the first line therapy is inappropriate.

Obtaining a Coverage Determination Request

- Complete a Coverage Determination Request form, which may be found on WellCare's website at http://www.wellcare.com/Provider/Medicare_FormsandDocuments
- Fax the Coverage Determination Request form to the Pharmacy Department. Refer to your state-specific Quick Reference Guides for the appropriate fax number, which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides>

WellCare's standard is to respond to Coverage Determination requests within seventy-two (72) hours for routine requests and twenty-four (24) hours for expedited requests from the time when WellCare receives the request.

The provider must provide medical history and/or other pertinent information when submitting a Coverage Determination request form for medical exception.

If the Coverage Determination request meets the approved P&T Committee's protocols and guidelines, the provider and/or pharmacy will be contacted with the Coverage Determination request approval. An approval letter is also sent to the member and a telephonic attempt is made to inform them of the approval.

If the Coverage Determination request is not a candidate for approval based on approved P&T Committee protocols and guidelines, it is initially reviewed by a clinical pharmacist and secondly reviewed by a medical director for final determination.

For those requests that are not approved, a follow-up Drug Utilization Review (DUR) form is faxed to the provider stating why the Coverage Determination request was not approved, including a list of the preferred drugs that are available as alternatives, if applicable. A denial letter is also sent to the member and a telephonic attempt is made to inform them of the denial.

Medication Appeals

To request an appeal of a Coverage Determination request decision, contact the Pharmacy Appeals Department via fax, mail, in person or phone. Refer to the state-specific Quick Reference Guides which may be found on WellCare's website at <http://www.wellcare.com/Provider/QuickReferenceGuides> for more information.

Once the appeal of the Coverage Determination request decision has been properly submitted and obtained by WellCare the request will follow the appeals process described in *Section VII Appeals & Grievances*.

XIII. WellCare Resources

On WellCare's website www.wellcare.com providers will have access to a variety of easy-to-use tools created to streamline day-to-day administrative tasks with WellCare. Please click the following links to access these materials as they are updated on a regular basis.

Medicare Forms and Documents

http://www.wellcare.com/Provider/Medicare_FormsandDocuments

Quick Reference Quick Reference Guides

<http://www.wellcare.com/Provider/QuickReferenceGuides>

Clinical Practice Guidelines

<http://www.wellcare.com/Provider/CPGs>

Clinical Coverage Guidelines

<http://www.wellcare.com/Provider/CCGs>

Provider Training

<http://www.wellcare.com/Provider/ProviderTraining>

Job Aids

http://www.wellcare.com/Provider/job_aids

XIV. WellCare Definitions

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

“Appeal” means a request for review of some action taken by or on behalf of WellCare.

“Benefit Plan” means a health benefit policy or other health benefit contract or coverage document (a) issued by WellCare or (b) administered by WellCare pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

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

“Centers for Medicare and Medicaid Services (“CMS”) means that United States federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

“Clean Claim” means a claim for Covered Services provided to a Member that (a) is received timely by WellCare, (b) has no defect, impropriety, or lack of substantiating documentation from the Member's medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional WellCare specific requirements in the WellCare Companion Guide, including all then current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for WellCare to (1) meet requirements of Laws and Program Requirements for reporting of Covered Services provided to Members, and (2) determine payor liability, and ensure timely processing and payment by WellCare. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

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

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

“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part.

“Encounter Data” means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

“FBDE” means Full Benefit Dual Eligible members who are eligible to have full Medicaid benefits (SLMB+ and QMB+)

“Formulary” means a list of covered drugs selected by WellCare in consultation with a team of health care providers on the Pharmacy and Therapeutics (P&T) Committee, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

“Grievance” means any complaint or dispute, other than one that involves a WellCare determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of WellCare, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

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

“Medicare Emergency Services” means covered inpatient and outpatient services that are (i) provided by a Provider qualified to furnish emergency services, and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

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

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

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

“PCP” means a primary care provider.

“Provider” means an individual or entity that has contracted to provide or arrange for the provision of Covered Services to Members under a Benefit Plan.

“QI” means Qualifying Individual whose income is between 120% and 135% of the Federal Poverty Level are considered partial dual eligible members since they are responsible for paying their Part A and Part B cost sharing. These members are not eligible to have full Medicaid benefits.

“QMB+” means Qualified Medicare Beneficiary whose income is no more than 80% of the Federal Poverty Level and are considered a zero cost share dual eligible member since they are not responsible for paying their Part A or Part B cost sharing. They also are eligible to have full Medicaid benefits.

“QMB” means Qualified Medicare Beneficiary whose income is between 80% and 100% of the Federal Poverty Level and are considered a zero cost share dual eligible member since they are not responsible for paying their Part A or Part B cost sharing. These members are not eligible to have full Medicaid benefits.

“Reopening” means a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

“SLMB+” means Specified Low-Income Medicare Beneficiary whose income is between 100% and 120% of the Federal Poverty Level and are considered a zero cost share dual eligible member since they are not responsible for paying their Part A or Part B cost sharing. They also are eligible to have full Medicaid benefits.

“SLMB” means Specified Low-Income Medicare Beneficiary whose income is between 100% and 120% of the Federal Poverty Level and are considered partial dual eligible members since they are responsible for paying their Part A and Part B cost sharing. These members are not eligible to have full Medicaid benefits.

“QDWI” means Qualified Disabled Working Individual whose income is between 135% and 200% of the Federal Poverty Level are considered partial dual eligible members since they are responsible for paying their Part A and Part B cost sharing. These members are not eligible to have full Medicaid benefits.

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

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