Criteria

WellCare uses the following criteria in making clinical decisions:

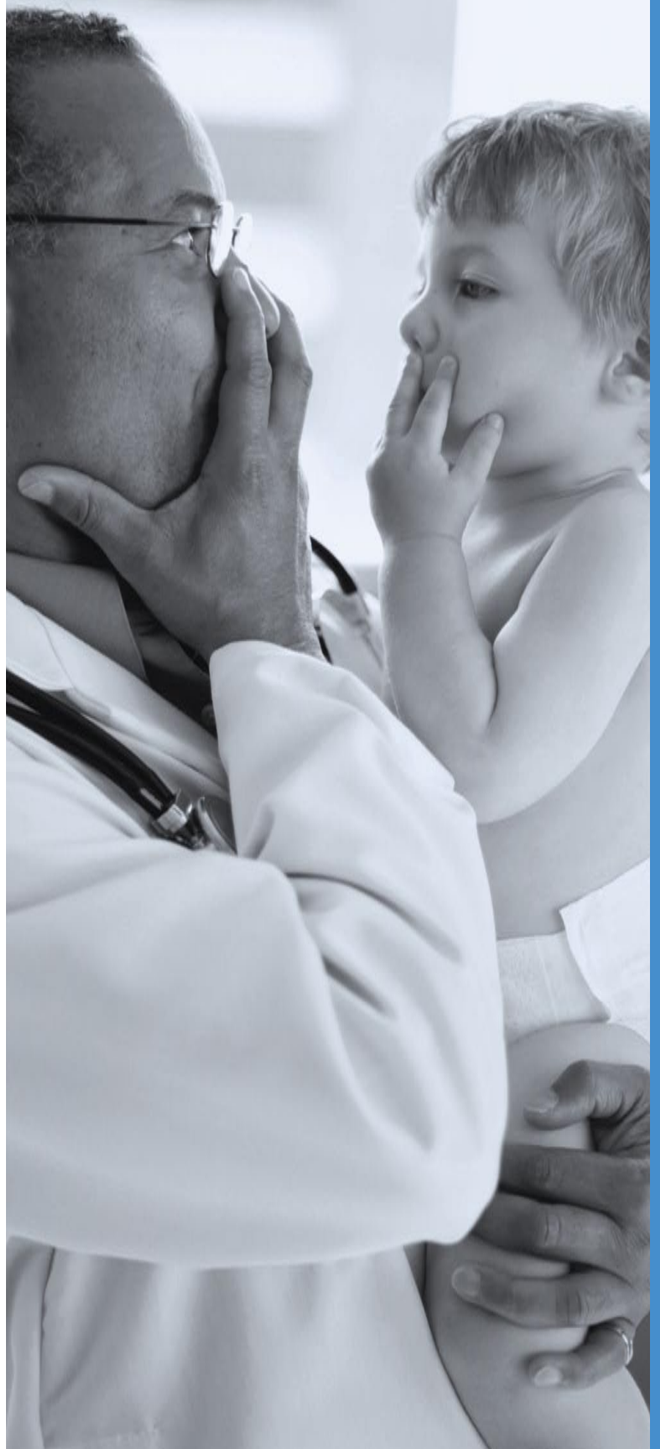
- Member benefits
- State and Federal regulations and laws
- InterQual™ (Severity of Illness/Intensity of Service criteria)
- Medicaid/Medicare Guidelines
- Hayes Health Technology Assessment (evidence-based, health technology assessments, new medical technology)

Continuity of Care

WellCare recognizes the need for continuity of care for members new to the plan. As a result, we are coordinating with DCH to obtain three months of claims and referral/authorization data on each new member. Special circumstances will exist and will be handled as follows:

- Members in the hospital when they enroll in WellCare will remain the financial responsibility of FFS Medicaid until the member is discharged from the hospital.
- Every effort will be made to honor prior authorized services until the new member has established a relationship with his/her new Primary Care Physician (PCP).
- Members with DME, home health, dialysis, hospice and OB open authorizations will be reviewed and every effort will be made to contact the member and/or the provider to either approve or transition the member to an in-network provider.

WellCare realizes that some Medicaid members may not have a telephone or permanent address. Because of this, continuity of care will depend on the working relationship of the PCP and our Utilization Management Team.



Provider Handbook

For additional information on these and other topics, please refer to WellCare's Provider Handbook. This handbook should be used as a reference source as it describes requirements and processes for administering our plan as outlined in our provider agreement. For a copy, log onto **http://georgia.wellcare.com** or contact a Provider Relations Representative.

WellCare® of Georgia, Inc.

Medical Management Objectives

Georgia Families
Choices for a Healthy Life

WCPC-GMD-048 04/07


Medical Management Objectives

At WellCare, we are committed to serving the needs of our key constituents including providers, members, and our government partners. For providers like you, that means being good business partners and providing medical services and management for members through:

- interventions to improve the quality of patient care;
- effective disease management and case management programs to assist members with difficult health issues;
- efficient member authorization submission and member eligibility verification processes;
- effective communication on a regular basis through a variety of quality improvement programs and fax alerts;
- feedback on utilization and performance relative to your peer group.

Quality Improvement Studies

A primary goal of the Georgia Families program is to engage members in actively managing, maintaining, or improving their current state of health. WellCare's Quality Improvement Program fosters selection of improvement initiatives that are deemed to be most meaningful to the member population.

Upcoming topics of studies include:

- Immunizations
- Health Check Screenings
- Asthma
- Member Satisfaction
- Blood Lead Testing
- Chronic Kidney Disease
- Provider Satisfaction
- Member Complaints

Education Materials

WellCare's Quality Improvement Program includes programs for Case and Disease Management for members with asthma, diabetes, HIV/AIDS, elevated lead levels, high-risk pregnancy, and other complex conditions. In addition, programs to ensure members are receiving Health Check screenings, lead screenings, detection of chronic kidney disease and immunizations are instituted to encourage members to obtain needed preventive health care screenings.

Included in our provider handbook are items ranging from adult and child health screening forms to "ALERTS", which are faxed to provider offices, regarding members' unique health needs. Also included are samples of inpatient chart flags that are affixed to hospital charts as a reminder of treatment guidelines.

Case Management

Criteria for each case management program differ. Members are screened to determine if one of the programs could make an impact on the member's health. If so, the member and provider are contacted to determine an individualized plan of care.

Available Case Management Programs include:

- Complex Case Management
- Pediatric Case Management
- Pediatric Lead Case Management
- Wound Case Management
- Prenatal/High Risk OB Case Management
- Transplant Case Management.

Preventive Health Care Visits

State and federal governments mandate that certain preventive services be provided to all eligible members. Preventive services result in improved outcomes, higher member satisfaction, and overall lower health care costs. As a condition of your provider agreement, you are required to cover certain preventive services. It is important that you know the preventive services that are required, outreach to your members and encourage them to make an appointment. You may use routine office visits to perform preventive services, however, ensure you combine the office visit codes with the necessary ICD-9 modifying code when submitting claims and/or encounters to WellCare.

Medical Management Reports

WellCare uses a variety of reports that we share with providers to improve the quality and efficiency of the care delivered to our members. We have found that sharing this information results in improvements, particularly when peer comparisons are available.

Reports are generally based on information we extract from claims payments made for services provided to our members. Thus, the submission of accurate claims information is critical to report accuracy.

Examples of data elements included in the reports are:

- Diagnosis
- Place of Service
- Cost of Service
- Provider Name
- Procedures
- Drugs Prescribed
- Provider Specialty
- Insurance type (e.g., Medicaid or Medicare)

Authorizations

WellCare's prior authorization and pre-certification process allows us the opportunity to identify members needing specialized services from our Utilization Management, Case Management, or Disease Management programs. Early identification and interventions may prevent unnecessary emergency room visits and hospital admissions for members.

Authorizations also result in quicker claims payments for providers as all of the necessary information is already entered into our claims payment system. This often minimizes the need for retro reviews and office audits.

Authorization Timeframes

WellCare's authorization process includes a determination on whether a request for a non-urgent service is medically appropriate and a covered service under the member's benefit plan. The standard time frame for this determination is usually between three to five days but no later than 14 calendar days after the request has been received. An extension may be granted for an additional 14 calendar days if a provider requests an extension or if WellCare justifies to the Department of Community Health (DCH) a need for additional information and that the extension is in the best interest of the member.

In some cases, when a provider indicates that the member's health or ability to function could be seriously harmed by waiting 14 days for a standard decision, an expedited determination may be made within 24 hours. An extension may also be granted for a expedited determination for up to five business days.

WellCare®