Dear Provider Partner:

At WellCare we value everything you do to deliver quality care to our members – your patients. Through our combined efforts we ensure that our members continue to trust us to help them in their quest to lead longer and more satisfying lives.

We’re committed to quality. That pledge demands the highest standards of care and service. We are constantly investing in people and programs, innovating, and working hard to remove barriers to care.

WellCare’s dedication to quality means that we are also committed to supporting you. We want to make sure that you have the tools you need to succeed. We will work with you and your staff to identify members with outstanding care gaps, and we will reward you for closing those gaps.

The enclosed provider manual is your guide to working with us, we hope you find it a useful resource. The highlighted area to the right depicts sections of the manual that directly address our mutual goal of delivering quality care.

Thank you again for being a trusted WellCare provider partner!

Sincerely,

Dr. Donald Fillipps
Medical Director
Children’s Medical Services Health Plan Florida
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Section 1: Welcome to Children’s Medical Services Health Plan

Overview
Children’s Medical Services (CMS) Health Plan is operated by WellCare of Florida, Inc., in partnership with the Florida Department of Health (DOH). WellCare of Florida, Inc., a subsidiary of WellCare Health Plans, Inc., (WellCare), provides managed care services targeted exclusively to government-sponsored healthcare programs, focused on Medicaid, CHIP and Medicare, including prescription drug plans and health plans for families and children. WellCare’s corporate office is located in Tampa, Florida. WellCare serves approximately 5.5 million Members. WellCare’s experience and commitment to government-sponsored healthcare programs enables WellCare to serve its Members and Providers as well as manage its operations effectively and efficiently.

Mission
Our Members are our reason for being. WellCare helps those eligible for government-sponsored healthcare plans live better, healthier lives.

Vision
To be a leader in government-sponsored healthcare programs in collaboration with our Members, Providers and government partners. WellCare fosters a rewarding and enriching culture to inspire our associates to do well for others and themselves.

Core Values
- **Partnership** – WellCare delivers excellent service to our Member, Provider and government partners. Members are the reason we are in business; Providers are our partners in serving our Members; and government partners are the stewards of the public’s resources and trust.
- **Integrity** – WellCare does the right thing to keep the trust of those we serve and with whom we work.
- **Accountability** – WellCare is responsible for the commitments we make and the results we deliver both internally and externally.
- **One Team** – WellCare demonstrates a collaborative “One Team” approach across all areas and put Members first in all we do.

Purpose of this Provider Manual
This Provider Manual is intended for WellCare-contracted (participating) CMS Health Plan Providers who offer healthcare service(s) to Members enrolled in the Children’s Medical Services Health Plan. This Manual serves as a guide to the policies and procedures governing the administration of the CMS Health Plan and is an extension of and supplements the Provider Participation Agreement (the Agreement) between WellCare and healthcare Providers, who include, without limitation: Primary Care Providers, Hospitals and Ancillary Providers (collectively, Providers).

The Manual is available on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid). A paper copy may be obtained, at no charge, upon request by contacting Provider Services or a Provider Relations representative.
See Appendix A for a regional map.

In accordance with the policies and procedures clause of the Agreement, participating WellCare 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 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 by WellCare 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.

The CMS Health Plan, operated by WellCare in partnership with DOH, is a specialty plan for children and youth with special healthcare needs. The CMS Health Plan serves children 0 to 20 years old who qualify for Medicaid or the state’s Children’s Health Insurance Program (CHIP) and who have a qualifying clinical diagnosis.

**Description of the Florida Medicaid program, CHIP and the SMMC Program**

**Medicaid** is the medical assistance program that provides access to healthcare for low-income families and individuals. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses. In 2014, the Florida Medicaid program implemented a new system through which Medicaid enrollees receive services. It is referred to as the Statewide Medicaid Managed Care (SMMC) program. Most Medicaid recipients must enroll in a health plan that was selected through a competitive procurement to participate in the SMMC program.

Medicaid is managed by the Florida Agency for Health Care Administration (Agency), otherwise known as AHCA. WellCare is contracted with the Agency to provide managed care services to Medicaid recipients enrolled with WellCare. WellCare is also contracted with DOH to operate their SMMC specialty plan for children and youth with special healthcare needs, otherwise known as the Children’s Medical Services Health Plan.

**Healthy Kids** is another Florida KidCare program managed by Florida Healthy Kids Corporation (Corporation), otherwise known as FHKC. It offers healthcare coverage for as little as $15–$20 per month. There are also low-cost, full-pay options, making Healthy Kids coverage available to every 5- to 18-year-old in Florida.

WellCare is contracted with the Corporation to provide managed care services to Florida Healthy Kids recipients enrolled with WellCare. WellCare is also contracted with DOH to operate the specialty plan for Florida Healthy Kids.

**American Recovery and Reinvestment Act of 2009**

WellCare may not impose enrollment fees, premiums or similar charges on Indians serviced by an Indian healthcare provider; Indian Health Service; and Indian Tribe, Tribal Organization, or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.
Covered Services
The following core benefits and services are provided to CMS Health Plan Members:

- Advanced Registered Nurse Practitioner Services
- Ambulatory Surgical Treatment Center Services
- Assistive Care Services
- Behavioral Health Services
- Behavior Analysis (BA) services *
- Birth Center and Licensed Midwife Services
- Chiropractic Services
- Clinic Services
- Child Health Checkup Services
- Dental Services *
- Immunizations
- Emergency Services (including Emergency Behavioral Health Services)
- Family Planning Services and Supplies
- Healthy Start Services
- Hearing Services
- Home Health Services and Nursing Care
- Hospice Services
- Hospital Services
- Laboratory and Imaging Services
- Medical Supplies, Equipment, Prosthesis and Orthoses
- Nursing Facility Services
- Optometric and Vision Services
- Physician Assistant Services
- Physician Services
- Podiatric Services
- Prescribed Drug Services
- Renal Dialysis Services
- Therapy Services
- Transplant Services
- Transportation Services

* For CHIP Title XXI recipients members only. Title XIX recipients receive dental services through the state’s dental plan

For the most up-to-date information on Covered Services, refer to the CMS Plan website at [http://www.floridahealth.gov/](http://www.floridahealth.gov/)

In Lieu of Services
The following in lieu of services are provided to CMS Health Plan Members:

- Ambulatory Setting Substance Use Disorder Treatment and Detoxification Services
- Crisis Stabilization – Behavioral Health
- Community Based Wrap Around Services
- Detoxification at Addiction Receiving Center
- Family Training and Counseling for Child Development
- Free Standing Psychiatric Services
- Infant Mental Health Screening
- Intensive Outpatient Services for Mental Health
- Intensive Outpatient Services for Substance Use Disorder
- Mobile Crisis
- Multi Systemic Therapy
- Psychiatric Partial Hospitalization – Mental Health
- Psychiatric Partial Hospitalization – Substance Use Disorder
- Self Help/Peer Support Services
- Short Term Residential
- Skilled Nursing

**Expanded Benefits**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver Behavioral Health Services for Non-Medicaid Caregivers</td>
<td>Covers caregiver counseling provided in individual or group setting for non-Medicaid caregivers of members to help address issues such as burnout, emotional distress, and depression.</td>
<td>Must be a non-Medicaid caregiver of a member</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Cell Phone Program</td>
<td>Members will receive a cell phone at no cost via Safelink/TracFone.</td>
<td>Includes 1000 monthly minutes for talk and unlimited text</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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<tr>
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</tr>
<tr>
<td>Computerized Cognitive Behavioral Analysis for Non-Medicaid Caregivers</td>
<td>Including, but not limited to the following: health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, health and behavioral interviews (individual, group, family (with or without the patient)</td>
<td>Must be a non-Medicaid caregiver of a member; unlimited with prior authorization</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>CVS Discount Card</td>
<td>CVS ExtraCare Health Card saves members 20% on thousands of CVS/pharmacy brand health-related items for members and their family. Discount applies to regularly priced items of $1 or more made at any CVS/pharmacy locations or online at <a href="http://www.cvs.com">www.cvs.com</a>.</td>
<td>One card per member</td>
<td>No</td>
</tr>
<tr>
<td>Doula Program for Pregnant Teens</td>
<td>Doula services for members with a goal of improved birth outcomes, reduced pre-term births, and improved prenatal care</td>
<td>For members ages 13 to 20</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
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<tr>
<td>Home-Delivered Meals (General)</td>
<td>Members may be eligible to receive 10 meals for nutritional support</td>
<td>10 meals per authorized request</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Home-Delivered Meals – Disaster Preparedness/Relief</td>
<td>One (1) emergency meal kit annually</td>
<td>One kit per member annually</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Home-Delivered Meals – Post-Facility Discharge (Hospital or Nursing Facility)</td>
<td>Members discharged within two weeks from an inpatient facility (Hospital, Skilled Nursing Facility or inpatient Rehabilitation) may be eligible to receive 10 meals per authorized request</td>
<td>10 meals per authorized request</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>Up to $250 per year for housing assistance and $75 limit per quarter to buy healthy food items</td>
<td>$250 per year plus $75 per quarter for health food items</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Individual Therapy Sessions for Caregivers</td>
<td>Provide individual therapy sessions to address behavioral health needs for caregivers of members</td>
<td>For caregivers of a member; unlimited visits with prior authorization</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Meals - Non-emergency Transportation Day Trips</td>
<td>Up to $200 per day, up to $1,000 per year, for trips greater than 100 miles from the member’s residence. Restrictions may apply for additional passengers.</td>
<td>Up to $200 per day, up to $1,000 per year for trips greater than 100 miles from member’s residence. Restrictions may apply for additional passengers.</td>
<td>Prior Authorization Required</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Limit of one per lifetime</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/ Limitations</td>
<td>Prior Authorization</td>
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</tr>
<tr>
<td>Newborn Circumcision</td>
<td>Provide circumcision coverage to members within prescribed limits</td>
<td>For members age 0-28 days&lt;br&gt;Once per lifetime, if medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Non-medical Transportation</td>
<td>Provide transportation services for non-medical appointments. Limited to trips within the member's home county/local area.</td>
<td>Not for member in a SNF/nursing home setting; up to two trips per month</td>
<td>No</td>
</tr>
<tr>
<td>Over-the-Counter (OTC)</td>
<td>Each head of household is eligible to receive $25 worth of OTC items each month that are mailed to their home</td>
<td>Monthly household limits do not carry over from month to month&lt;br&gt;Limited to items listed in the OTC catalog</td>
<td>No</td>
</tr>
<tr>
<td>Swimming Lessons (Drowning Prevention)</td>
<td>Members under age 21 can receive $150 per year for swimming lessons</td>
<td>Space is limited&lt;br&gt;Prior Authorization Required</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Transition From SNF to Private Home Setting</td>
<td>Up to $2,500, per lifetime for the child's private home setting if they are in a skilled nursing facility and transitioning to a private home setting within the community</td>
<td>Up to $2,500 per member per lifetime&lt;br&gt;Prior Authorization Required</td>
<td>Prior Authorization Required</td>
</tr>
</tbody>
</table>
## Special Programs For Children’s Medical Services Health Plan Members

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Devices</td>
<td>Receive items to help members move around the home</td>
<td>One item per plan year</td>
<td>No</td>
</tr>
<tr>
<td>Benefit Counseling</td>
<td>Receive benefit counseling services</td>
<td>Three sessions per plan year</td>
<td>No</td>
</tr>
<tr>
<td>Carpet Cleaning</td>
<td>Provide carpet cleaning service for qualified members with asthma. Benefit allowed by household and based on diagnosis.</td>
<td>For qualified members with asthma Two carpet cleanings per year</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Community Connections Help Line</td>
<td>FREE Community Connections Help Line to connect you to community services such as utility assistance, food banks and transportation in your community</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Financial Counseling</td>
<td>Receive financial counseling services</td>
<td>Six sessions per plan year</td>
<td>No</td>
</tr>
<tr>
<td>Health/Wellness Coaches</td>
<td>Access to a health/wellness coach to receive education and</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/ Limitations</td>
<td>Prior Authorization</td>
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</tr>
<tr>
<td>Healthy Rewards</td>
<td>Members receive rewards who complete specific preventive health, wellness, and engagement milestones</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>HEPA Filter Vacuum Cleaner</td>
<td>Provide qualified members with asthma with a vacuum cleaner with HEPA filter. Using HEPA filters can trap these pollutants and may help bring allergy relief. HEPA stands for high-efficiency particulate air.</td>
<td>For qualified members with asthma</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Hypoallergenic Bedding</td>
<td>Eligible members with asthma can get an allowance to buy hypoallergenic bedding</td>
<td>For qualified members with asthma</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Assessment, hands-on care, education and guidance to caregivers and members about nutrition</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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<td>--------------------</td>
</tr>
<tr>
<td>Pest Control</td>
<td>Receive pest control services</td>
<td>Up to $500 annual per member's household</td>
<td>Prior Authorization Required</td>
</tr>
</tbody>
</table>
| Steps2Success       | Reading Scholarships: FREE reading scholarships for qualified members who are in pre-kindergarten to 12th grade who want to improve their reading skills  
General Educational Development® (GED®) Exam:  
Members can take the GED test for FREE if they are age 16 or older and do not have their high school diploma  
Reading Scholarship: Space is limited  
GED exam: One voucher per year per member (covers four tests) |                                               | No |
| Tutoring Services   | Receive 12 tutoring sessions to help remove educational barriers            | Up to two hours of tutoring time per session   | No |
| Wellness Items      | Members can choose wellness items/supplies to help with healthy living     | Up to $200 per member per year                | No |
Excluded Services

The following services are not covered by the CMS Plan but are available to eligible Medicaid members through Medicaid FFS:

- Behavioral Analysis (BA) services
- CHD Certified Match Program services
- Developmental Disabilities Individual Budgeting (iBudget) home and community-based services (HCBS) Waiver services
- Familial Dysautonomia HCBS Waiver services
- Hemophilia Factor-related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program services
- ICF/IID services
- Model HCBS Waiver services
- Newborn hearing services
- Prescribed Pediatric Extended Care services (PPEC)
- School-based services provided through the Medicaid Certified School Match Program
- PACE services
- Substance Abuse County Match Program services

The following services are not covered by the CMS Plan for Title XXI members:

- Home and Community Based Services
- Behavioral health services for BNet enrolled members

CMS Health Plan Eligibility

The specialty population eligible to enroll in the CMS Health Plan will consist of only those recipients who meet the following criteria:

a. Identified pursuant to a rule(s) promulgated by DOH; and
b. Children ages 0-20 years with a qualifying condition and who are eligible for Medicaid or CHIP.

Provider Services

Providers may contact the appropriate departments by referring to the Quick Reference Guide at www.wellcare.com/Florida/Providers/Medicaid. Provider Relations representatives are available to assist in many requests for participating Providers. If you don’t know who your Provider Relations representative is, you may contact FloridaProviderRelations@wellcare.com or call 1-407-551-3200, option 2.

Provider Relations representatives will conduct initial and ongoing training in order to ensure compliance with program standards and contractual obligations. Provider trainings may be accomplished by Provider orientations, newsletters, online learning modules, emails, faxes, letters, on-site training, summits, webinars or other means. The company’s Provider Relations Staff is responsible for:

A. Initial Orientation. Initial orientation of Providers shall be performed, in person or via webinars, at the Provider’s office, or at a mutually agreed upon site within 30 days of placing a newly contracted Provider, or Provider group, on active status or at the first availability of the Company and Provider after those days have expired. The orientation can be administered in a variety of settings (e.g., group, seminar, or one-on-one).
Orientation modules are also available on our website where providers can attest to the modules they have completed. Bi-weekly webinars hosted by Provider Relations staff are available to newly contracted and existing providers.

Providers are required to complete a comprehensive set of training modules within 30 days of contracting. Providers have the option of completing their training via web modules located on the Provider portal (with an attestation requirement) or in-person with their PR Representative. A Provider Visit Information Form is used to document the in-person orientation and outline all topics covered. This form is signed and dated by the Provider, along with the names of participants who were present, and any follow-up items. Evidence of the initial orientation is stored in our internal customer relationship management system, along with the signed Provider Visit Information Form.

During the orientation, our Provider portal is used to navigate the training documents so Providers are aware of the various tools and resources available for everyday use. Some of the topics discussed during initial orientation will include:

- Managed Care Program and Services
- Eligibility and Benefits
- Rights and Responsibilities
- Member Care and Quality
- Authorizations
- WellCare’s Compliance Program
- Billing, Payment, and Encounters, including Electronic Visit Verification (EVV)
- Appeals and Grievances
- WellCare’s Policies and Procedures
- Telemedicine Services
- Model of Care
- Timely Access Requirements
- Continuity of Care and Transition of Care
- Enrollees with Special Needs
- Review of the Provider Manual

B. Ongoing Training. Ongoing training shall be provided as necessary to meet the requirements outlined in either WellCare or the DOH contract, including any contract amendments, in order to ensure compliance with program standards. Ongoing monthly webinars are also conducted in adherence with contractual requirements. Ad Hoc trainings may be initiated, as necessary, to address identified issues and updates as proposed by the plan, State or the Provider. Methods of training include group orientations, seminars and summits, one-on-one Provider sessions, joint operating committee (JOC) meetings, webinars, phone calls, emails, etc.

Provider Relations representatives are available to provide up-to-date information on trainings provided.

**Interactive Voice Response (IVR) System**
WellCare’s toll-free Provider Help Line features Interactive Voice Response (IVR) system capabilities, which allow providers and their staff to expedite Provider verification and authentication within the IVR. Highlights of our IVR system include:
• Provider/Member account information is sent directly to the Provider Help Line agent’s desktop from the IVR validation process, so Providers do not have to re-enter information
• Full speech capability, allowing Providers to speak their information or use the touchtone keypad

Self-Service features
• Ability to receive Member eligibility information
• Ability to receive Member co-pay information
• Ability to request authorization and/or status information
• Unlimited claims information on full or partial payments
• Receive status for multiple lines of claim denials
• Automatic routing to the Provider Claims Support (PCS) claims adjustment team to dispute a denied claim
• Receive information about rejected claims

TIPS for using our IVR System
Providers should have the following information available with each call:
• WellCare-issued Provider ID number
• NPI or Tax ID for validation, if Providers do not have their WellCare-issued ID
• For claims inquiries – the Member’s CMS Health Plan-issued member ID number, date of birth, date of service and dollar amount
• For authorization and eligibility inquiries – the Member’s CMS Health Plan-issued member ID number and date of birth

Benefits of using self-service
• 24/7 – data availability
• No hold times
• Providers may work at their own pace
• Access information in real time
• Unlimited number of Member claim status inquiries
• Direct access to PCS – No transfers

The Phone Access Guide is posted on www.wellcare.com/Florida/Providers/Medicaid under the Providers section, “Overview & Resources.”

Website Resources
Our website, www.wellcare.com/Florida/Providers, offers a variety of tools to assist Providers and their staff.

Available resources include:
• Provider Manual
• Quick Reference Guide
• Clinical Practice Guidelines
• Clinical Coverage Guidelines
• Forms and documents
• Pharmacy and Provider look-up (directories)
• Authorization look-up tool
• Web-based training materials and guides
• Newsletters
• Member rights and responsibilities
• Privacy statement and notice of privacy practices

Secure Provider Portal – Benefits of Registering
Our secure online Provider Portal offers immediate access to an assortment of useful tools. Providers can create unlimited individual sub-accounts for staff members, allowing for separate billing and medical accounts.

All Providers who create a password using their WellCare-issued Provider Identification (Provider ID) number have access to the following features:

• **Claims submission status and inquiry:** Submit a new claim, check the status of an existing claim, and customize and download reports

• **Member eligibility and co-payment information:** Verify Member eligibility and obtain specific co-payment information

• **Authorization requests:** Submit authorization requests, attach clinical documentation and check authorization status. Providers can also print and/or save authorization forms

• **Pharmacy services and utilization:** View and download a copy of WellCare’s Preferred Drug List (PDL), see drug recalls, access pharmacy utilization reports and obtain information about WellCare pharmacy services

• **Web-based training:** Take required training courses and complete attestations online

• **Reports:** Access reports such as active Members, authorization status, claims status, eligibility status, pharmacy utilization and more

• **Provider news:** View the latest important announcements and updates

• **Personal inbox:** Receive notices and key reports regarding claims, eligibility inquiries and authorization requests

How to Register
Please visit [www.wellcare.com/Florida/Providers](http://www.wellcare.com/Florida/Providers). For more detail, please refer to the Provider Resource Guide at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid).

After registering on WellCare’s website, Providers should retain username and password information for future reference.

For more information about our Web capabilities, please contact Provider Services or a Provider Relations representative.

Additional Resources
The Quick Reference Guide contains information about our secure online Provider Portal, Member eligibility, authorizations, filing paper and electronic claims, appeals and more. For direct access to our Provider Services team for day-to-day administrative
tasks, please see the *WellCare Quick Access Guide to Provider Services*. Both documents can be found at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid).
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview
This section is an overview of guidelines for which all participating Children’s Medical Services (CMS Health Plan) Providers are accountable. Please refer to the Provider Participation Agreement (the Agreement) or contact a Provider Relations representative for clarification of any of the following.

Participating 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 our efforts to monitor compliance with our CMS Health Plan contract(s), approved AHCA 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 Members as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of healthcare [42 C.F.R. § 422.504(a)(3)(iii).]
- Use physician extenders appropriately. Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) should provide direct Member care within the scope or practice established by the rules and regulations of the approved AHCA, 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 physician extender titles (examples: MD, DO, ARNP, PA) to Members and to other healthcare professionals
- Honor at all times any Member request to be seen by a physician rather than a physician extender
- Administer, within the scope of practice, treatment for any Member in need of healthcare services
- Maintain the confidentiality of Member information and records
- Allow WellCare to use Provider performance data for quality improvement activities
- Respond promptly to WellCare’s request(s) for medical records in order to comply with regulatory requirements
- Maintain accurate medical records and adhere to all WellCare policies governing content and confidentiality of medical records as outlined in Section 3: Quality Improvement and Section 8: Compliance
- Ensure that:
  - All employed physicians and other healthcare practitioners and Providers comply with the terms and conditions of the Agreement between Provider and WellCare
To the extent physician maintains written agreements with employed physicians and other healthcare practitioners and Providers, such agreements contain similar provisions to the Agreement

Physician maintains written agreements with all contracted physicians or other healthcare 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 Members and non-WellCare Members
- Ensure that the hours of operation offered to WellCare Members is no less than those offered to commercial Members or comparable Medicaid Fee-For-Service recipients if Provider serves only Medicaid recipients
- Not deny, limit or condition the furnishing of treatment to any WellCare Member on the basis of any factor that is related to health status, including, but not limited to, the following:
  - Medical condition, including mental as well as physical illness
  - Claims experience
  - Receipt of healthcare
  - Medical history
  - Genetic information
  - Evidence of insurability
  - Including conditions arising out of acts of domestic violence, or disability
- Freely communicate with and advise Members regarding the diagnosis of the Member’s condition and advocate on Member’s behalf for Member’s health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services
- Identify Members that are in need of services related to children’s health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation, substance use disorder or other behavioral health issues. 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
Excluded or Prohibited Services
Providers must verify patient eligibility and enrollment prior to service delivery. CMS Health Plan is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, such as specific transplant services, are administered outside of the managed care program.

For Medicaid, excluded services are defined as those services that Members may obtain through other applicable Medicaid programs, including the Medicaid Fee-For-Service system, and for which the CMS Health Plan is not financially responsible. These services may be paid for by the Agency on a Fee-For-Service basis or other basis. Providers are required to determine eligibility and Covered Services prior to rendering services. In the event the service(s) is (are) excluded, Providers must submit reimbursement for services directly to the Agency. In the event the service(s) is (are) prohibited, neither CMS Health Plan nor the Agency is (are) financially responsible. For more information on prohibited services, refer to the Agency’s website at ahca.myflorida.com.

Identifying and Reporting of Abuse, Neglect and Exploitation of Enrollees
Providers are responsible for the screening and identification of CMS Health Plan enrollees who are abused, neglected or exploited, including the identification of victims of human trafficking. Providers are also required to report the identification of Members who fall into the above categories.

Providers may be asked to cooperate with WellCare to provide services or arrange for the Member to change locations. Training regarding abuse, neglect and exploitation is at www.wellcare.com/Florida/Providers/Medicaid/Training.

To report suspected abuse, neglect or exploitation of enrollees, Providers should call the Florida Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873) (TDD 711 or 1-800-955-8771). The toll-free number is available 24 hours a day. If a Provider sees a CMS Health Plan enrollee in immediate danger, they should call 911. Providers may report suspected abuse online at http://www.myffamilies.com/service-programs/abuse-hotline.

Timely Access Standards
All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member’s needs. CMS Health Plan will comply with DOH’s requirement to have the required participating PCPs by region, offer after hours appointment availability to CMS Health Plan enrollees.

WellCare shall monitor Providers against these standards to ensure Members can obtain needed health services within the acceptable appointment time frames, in-office waiting times and after-hours standards. Hours of operation offered for CMS Health Plan enrollees must be no less than those offered to commercial Members or comparable Medicaid Fee-For-Service recipients if Provider serves only Medicaid recipients. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.
<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent</td>
<td>Within 48 hours of the request</td>
</tr>
<tr>
<td>Sick</td>
<td>Within 7 calendar days of the request</td>
</tr>
<tr>
<td>Outpatient Behavioral Health</td>
<td>Within 14 days of the request</td>
</tr>
<tr>
<td>Ancillary services</td>
<td>Within 14 days of the request</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Within 30 days of the request</td>
</tr>
<tr>
<td>Specialist</td>
<td>Within 60 days of the request</td>
</tr>
</tbody>
</table>

In-office waiting times for primary care visits, specialty and urgent care, optometry services, and lab and X-ray services shall not exceed 30 minutes.

PCPs must provide or arrange for coverage of services, consultation or approval for referrals 24 hours a day, seven days a 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
- An answering system with the option to page the physician for a return call within a maximum of 30 minutes
- An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes

See Section 10: Behavioral Health for mental health and substance use disorder access standards.

**Responsibilities of All Providers**

The following is a summary of responsibilities specific to all Providers who render services to CMS Health Plan Members. These are intended to supplement the terms of the Agreement, not replace them. In the event of a conflict between this Provider Manual and the Agreement, the Agreement shall govern.

**Provider Identifiers**

All participating Providers (with the exception of atypical providers) are required to have a National Provider Identifier (NPI). For more information on NPI requirements, refer to Section 5: Claims.

Providers who are not already enrolled with the Florida Medicaid program, and who perform services for CMS Health Plan Members, must also obtain a Florida Medicaid Provider ID. The NPI associated to a providers Florida Medicaid Provider ID is used to submit a Claim or Encounter Data for the services rendered under WellCare. It is the Providers’ responsibility to obtain the Florida Medicaid ID and ensure the billing/rendering NPI and taxonomy codes billed on a Claim or Encounter match how the Provider is registered with AHCA.

**Advance Directives**

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 wills and Advance Directives. This allows them to designate another person to make a decision should they become mentally or physically unable to do so. WellCare provides information on Advance Directives in the Member Handbook.

Information regarding living wills 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 and Address Changes**

Prior notice to a Provider Relations representative or Provider Services is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number (Tax ID or 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, Providers must adhere to the following terms:

- Any contracted Provider must give at least 90 days' prior written notice to WellCare before terminating their relationship with WellCare “without cause,” unless otherwise agreed to in writing. Requests can be emailed to the Provider Relations Department at FloridaProviderRelations@wellcare.com in addition to sending via mail and facsimile, as long as sufficient notice is provided as indicated above. This ensures that adequate notice may be given to CMS Health Plan Members regarding the Provider's participation status with CMS Health Plan. Please refer to the Agreement for the details regarding the specific required days for providing termination notice, as the Provider 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.

- Members in active treatment may continue care when such care is Medically Necessary, through the completion of treatment of a condition for which the Member was receiving at the time of the termination or until the Member selects another treating Provider, for a minimum of 60 days, not to exceed six months after the Provider termination. For pregnant Members who have initiated a course of general care, regardless of the trimester in which care was initiated, continuation shall be provided until the completion of postpartum care. Please refer to Section 6: Credentialing of this Manual for specific guidelines regarding rights to appeal plan termination (if any).

Please note that we will notify in writing all appropriate agencies and/or Members prior to the termination effective date of a participating Primary Care Provider (PCP), hospital, specialist or significant ancillary Provider within the service area as required by program requirements, and 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 Healthcare Needs
Members with special healthcare needs include Members with the following conditions:

- Intellectual disabilities 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
- Children with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care
- Related populations eligible for SSI

The following is a summary of responsibilities specific to Providers who render services to WellCare Members who have been identified with special healthcare 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 healthcare 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
- Ensure the Member’s privacy is protected as appropriate during the coordination process

For more information on Utilization Management for Members with special healthcare needs, refer to Section 4: Utilization Management, Case Management and Disease Management.

Responsibilities of Primary Care Physicians (PCPs)
The following is a summary of responsibilities specific to PCPs who render Services to CMS Health Plan 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
• See Members for an initial office visit and assessment within the first 90 days of enrollment in WellCare
• Coordinate, monitor and supervise the delivery of Medically Necessary primary and preventive care services to each Member, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for Members under the age of 21
• Maintain a ratio of Members to full-time equivalent (FTE) physicians as follows:
  o 1 physician FTE per 675 Members
  o 1 advanced registered nurse practitioner (ARNP) FTE for every 750 Members above 675
  o 1 physician assistant (PA) FTE for every 750 Members above 675
• Ensure each time a referral is made of potentially eligible women, infants and children to the Women, Infants, and Children (WIC) program for nutritional assistance, and that copies of the referral are provided to the Member and kept in the Member’s medical record.
• Assure Members are aware 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® (Healthcare Effectiveness Data and Information Set) service
• Submit encounters. For more information on encounters, refer to Section 5: Claims
• Ensure Members utilize network Providers. If unable to locate a participating WellCare Provider for services required, contact Clinical Services for assistance. Refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid
• Comply with and participate in corrective action and performance improvement plan(s)

**Vaccines for Children Program**
Providers must participate in the Vaccines for Children Program (VFC). The VFC is administered by the Department of Health, Bureau of Immunizations. The VFC provides vaccines at no charge to physicians and eliminates the need to refer children to county health departments (CHDs) for immunizations. Title XXI CMS Health Plan Members (CHIP) over age 1 do not qualify for the VFC program. Providers should bill WellCare directly for immunizations provided to these participants. WellCare covers and reimburses participating Providers for immunizations covered by Medicaid, but not provided through VFC. Providers who are directly enrolled in the VFC program must maintain adequate vaccine supplies.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**
Any Provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Services are responsible for:

• Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible Members in accordance with
Federal regulation 42 U.S.C. § 1396d(r)(5) and the Periodicity Schedule provided by the American Academy of Pediatrics (AAP)

- Referring the Member to an out-of-network Provider for treatment if the service is not available within WellCare’s network
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines
- Providing vaccinations in conjunction with EPSDT/Well-child visits. Providers are required to use vaccines available without charge under the Vaccines for Children (VFC) Program for Medicaid children
- Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits
- Requesting Prior Authorization for Medically Necessary EPSDT special services in the event other health care, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Florida Medicaid Program
- Monitoring, tracking and following up with Members:
  - Who have not had a health assessment screening
  - Who miss appointments to assist them in obtaining an appointment
- Ensuring Members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with Members to ensure they receive the necessary medical services
- Assisting Members with transition to other appropriate care for children who age-out of EPSDT services

Providers will be sent a monthly membership list that specifies the health assessment eligible children who have not had an encounter within 120 days of joining the CMS Health Plan or are not in compliance with the EPSDT Program.

Provider compliance with Member monitoring, tracking and follow-up will be assessed through random medical record review audits conducted by the our Quality Improvement Department, and corrective action plans will be required for Providers who are below 80% compliance with all elements of the review.

For more information on EPSDT Covered Services, refer to Section 1: Welcome to WellCare. For more information on the Florida Medicaid EPSDT Periodicity Schedule, refer to the Agency’s website at ahca.myflorida.com. For more information on the Periodicity Schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx.

Primary Care Offices

PCPs provide comprehensive primary care services to CMS Health Plan Members. Primary care offices participating in CMS Health Plan’s Provider network have access to the following services:

- Support of the Provider Relations, Provider Services, Clinical Services and Marketing and Sales departments, as well as the tools and resources available on WellCare’s website at www.wellcare.com/Florida/Providers
- Information on WellCare network Providers for the purposes of referral management and discharge planning
Closing of Physician Panel
When requesting closure of the Provider’s panel to new and/or transferring CMS Health Plan Members, PCPs must:

- Submit the request in writing at least 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 CMS Health Plan Members who were provided services before the closing of the panel
- Submit written notice of the reopening 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 CMS Health Plan Members, Providers should make arrangements with another WellCare-contracted (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 CMS Health Plan Members. For additional information, please refer to Section 6: Credentialing.

In nonemergency cases, should a Provider have a covering physician/Provider who is not contracted and credentialed with WellCare, he or she should contact WellCare for approval. For more information, refer to the Quick Reference Guide on our website at www.wellcare.com/Florida/Providers/Medicaid.

Termination of a Member
A WellCare Provider may not seek or request to terminate his/her relationship with a Member, or transfer a Member to another Provider of care, based upon the Member’s medical condition, amount or variety of care required, or the cost of Covered Services required by the CMS Health Plan 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 CMS Health Plan Member until such time that written notification is received from CMS Health Plan 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 CMS Health Plan 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 noncompliance with treatment or uncooperative behavior is impairing the ability to care for and treat the Member effectively.

The Provider should complete a “PCP Request for Transfer of Member Form,” attach supporting documentation and fax the form to our Customer Service Department. A copy of the form is available on our website at www.wellcare.com/Florida/Providers/Medicaid/Forms.
Health Information Exchange
WellCare is dedicated to improving the health and quality of life of its Members and actively supports the statewide implementation of the Florida Health Information Exchange (HIE). The HIE means the secure electronic information infrastructure created by the state of Florida for sharing health information among healthcare organizations and offering healthcare Providers the functionality to support meaningful use and a high level of patient-centered care. WellCare’s goal is to support Providers in connecting with the Florida HIE. The HIE is a secure, interoperable network in which participating Providers with certified electronic health record (EHR) technology can use to locate and share needed patient information and send Direct Secure Messages (DSMs) between each other which results in improved coordination of care among physician practices, hospitals and labs, and across the various health systems.

Please visit [www.florida-hie.net](http://www.florida-hie.net) to obtain more information on this program and guidance on how Providers can make the HIE connection.

Domestic Violence and Substance Use Disorder Screening
PCPs should identify indicators of substance use disorder or domestic violence and offer referral services to applicable community agencies. Sample screening tools for domestic violence and substance use disorder are located on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid/Forms](http://www.wellcare.com/Florida/Providers/Medicaid/Forms).

Healthy Rewards Program
CMS Health Plan believes healthy behaviors lead to effective medical care for all Members. CMS Health Plan Members and their guardians are encouraged to manage their health needs, start and/or enhance habits that positively impact their health status, and take advantage of available preventive screenings. To support this, CMS Health Plan offers the Healthy Rewards program to Members. The program includes incentives for smoking cessation, weight loss and substance use disorder treatment. Members can receive either a reloadable debit card or a gift card for completing specific preventive health, wellness, and engagement milestones.

Title XIX Healthy Rewards Chart

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Activity Criteria</th>
<th>Incentive Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically approved stop smoking program</td>
<td>Member can complete three telephonic sessions with a health coach or complete an approved smoking cessation program</td>
<td>$10</td>
</tr>
<tr>
<td>Medically directed weight loss program</td>
<td>Member can complete six telephonic sessions with a health coach or complete an approved weight loss program</td>
<td>$10</td>
</tr>
<tr>
<td>Alcohol or substance use disorder treatment program</td>
<td>Member can complete a telephonic session with a health coach (includes receiving educational material and accept referral to a community treatment program) or complete an approved substance use disorder treatment program within their community</td>
<td>$10</td>
</tr>
<tr>
<td>Focus Area</td>
<td>Activity Criteria</td>
<td>Incentive Value</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>New Enrollee Healthy Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial PCP visit</td>
<td>Initial PCP visit in the first 90 days on the plan</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Children’s Healthy Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-child visit: 0-15 months</td>
<td>Well-child visit per periodicity schedule (reward for each visit, up to six visits)</td>
<td>$10</td>
</tr>
<tr>
<td>Child health checkup: 3-6 years</td>
<td>Child health checkup visit, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (reward for each visit)</td>
<td>$25</td>
</tr>
<tr>
<td>Adolescent checkup: 12-20 years</td>
<td>Adolescent checkup visit (reward for each visit)</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Healthy Pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal care visit</td>
<td>Members must complete a prenatal visit during their first trimester or within 42 days of enrollment</td>
<td>$25</td>
</tr>
<tr>
<td>Postpartum Care Visit</td>
<td>Attend one postpartum visit 21-56 days after the birth of the baby</td>
<td>$25</td>
</tr>
<tr>
<td>Completion of prenatal visit</td>
<td>Members who complete a prenatal visit will have the choice to receive one of the reward options listed:</td>
<td>Choice of a stroller, portable playpen, car seat or six packs of diapers</td>
</tr>
<tr>
<td><strong>Diabetic Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>Complete eye exam (Members with diabetes ages 18-20)</td>
<td>$25</td>
</tr>
<tr>
<td>HgbA1C control</td>
<td>Complete HgbA1C lab test (Members with diabetes ages 18-20)</td>
<td>$25</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>Complete blood pressure check (members with diabetes ages 18-20)</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Women’s Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia screening</td>
<td>Completion of annual screening for female members ages 16-20</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Adult Wellness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult wellness screening</td>
<td>Complete annual adult screening (wellness visit for members age 20)</td>
<td>$25</td>
</tr>
</tbody>
</table>
# Title XXI Healthy Rewards Chart

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Activity Criteria</th>
<th>Incentive Value</th>
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<td>Medically approved stop smoking program</td>
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<td>Member can complete six telephonic sessions with a health coach or complete an approved weight loss program</td>
<td>$10</td>
</tr>
<tr>
<td>Alcohol or substance use disorder treatment program</td>
<td>Member can complete a telephonic session with a health coach (includes receiving educational material and accept referral to a community treatment program) or complete an approved substance use disorder treatment program within their community</td>
<td>$10</td>
</tr>
<tr>
<td><strong>New Enrollee Healthy Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial PCP visit</td>
<td>Initial PCP visit in the first 90 days on the plan</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Children’s Healthy Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-child visit: 0-15 months</td>
<td>Well-child visit per periodicity schedule (reward for each visit, up to 6 visits)</td>
<td>$10</td>
</tr>
<tr>
<td>Child health checkup: 3-6 years</td>
<td>Child health checkup visit, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (reward for each visit)</td>
<td>$25</td>
</tr>
<tr>
<td>Adolescent checkup: 12-19 years</td>
<td>Adolescent checkup visit (reward for each visit)</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Healthy Pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal Care Visit</td>
<td>Members must complete a prenatal visit during their first trimester or within 42 days of enrollment</td>
<td>$25</td>
</tr>
<tr>
<td>Postpartum Care Visit</td>
<td>Attend one postpartum visit 21-56 days after the birth of the baby</td>
<td>$25</td>
</tr>
<tr>
<td>Completion of Prenatal Visit</td>
<td>Members who complete a prenatal visit will have the choice to receive one of the reward options listed:</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>Complete eye exam (Members with diabetes ages 18-19)</td>
<td>$25</td>
</tr>
<tr>
<td>HgbA1C control</td>
<td>Complete HgbA1C lab test (Members with diabetes ages 18-19)</td>
<td>$25</td>
</tr>
</tbody>
</table>
### Focus Area Activity Criteria Incentive Value

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Activity Criteria</th>
<th>Incentive Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure control</td>
<td>Complete blood pressure check (members with diabetes ages 18-19)</td>
<td>$25</td>
</tr>
<tr>
<td>Women’s Heath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia screening</td>
<td>Completion of annual screening for female members ages 16-19</td>
<td>$25</td>
</tr>
</tbody>
</table>

**Smoking Cessation**

PCPs should direct Members who smoke and wish to quit smoking to call WellCare’s Customer Service Department and ask to be directed to the Smoking Cessation Program. A health coach will work with Members through tailored interactions based on their individual needs and health objectives associated with smoking cessation.

PCPs can also reference the Agency for Health Care and Research & Quality’s Smoking Cessation *Quick Reference Guide*, which is available on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid) or by contacting a Provider Relations representative.

**Weight Loss**

Providers should direct Members with a high body mass index (BMI) and who wish to achieve a healthy weight to call the CMS Health Plan Customer Service Department and ask to be directed to the Medically Directed Healthy Weight program. A health coach will work with Members through tailored interactions based on their individual needs and health objectives associated with weight loss.

**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 ensure that the associates of WellCare value diversity within the organization, to see that Members in need of linguistic services receive adequate communication support, and to ensure that the needs of our Members with disabilities and their families are identified and fully addressed. In addition, WellCare is committed to having its 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 who have potential cultural, linguistic or disability-related barriers for which alternative communication methods are needed;
- Use culturally sensitive and appropriate educational materials based on the Member’s race, ethnicity, condition of disability, and primary language spoken;
- Make resources available to address 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 healthcare disparities in the minority populations WellCare serves.
Culturally and Linguistically Appropriate Services (CLAS) are healthcare services provided that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent healthcare and services requires that healthcare Providers and/or their staff possess a set of attitudes, skills, behaviors and policies that enable the organization and staff to work effectively in cross-cultural situations.

The components of WellCare’s Cultural Competency program include:

- **Data Analysis** – WellCare analyzes data on the populations in each region it serves for the purpose of learning about that region’s cultural and linguistic needs, as well as any health disparities specific to that region. Such analyses are performed when WellCare enters a new market and regularly thereafter, depending on the frequency with which new data become available. Data sources and analysis methods include the following:
  - Demographic data available from the U.S. Census and any special studies done locally
  - Claims and Encounter Data to identify the healthcare needs of the population by identifying the diagnostic categories that are the most prevalent
  - Member requests for assistance, or Member Grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle
  - Data on race, ethnicity and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers

- **Community-Based Support**:
  - WellCare reaches out to community-based organizations that support racial and ethnic minorities, and the disabled, to ensure that existing community resources for Members who have special needs are used to their full potential. The goal is to coordinate the deployment of both community and WellCare resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population
  - WellCare develops and maintains grassroots sponsorships that enhance its effort to reach low-income communities. WellCare also provides opportunities for building meaningful relationships that benefit all Members of the communities. These sponsorships are coordinated with Providers, community health fairs and public events.

- **Diversity and Language Abilities of WellCare**:
  - WellCare recruits diverse, talented staff to work in all levels of the organization. WellCare does not discriminate with regard to race, religion or ethnic background when hiring staff
  - WellCare ensures that bilingual staff Members are hired for functional units that have direct contact with Members to meet the needs identified. Spanish is the most common translation required. Whenever possible, WellCare will also distinguish place of origin of its Spanish-speaking staff to ensure sensitivity to differences in cultural backgrounds, language idioms and accents.
  - Where WellCare enrolls significant numbers of Members who speak languages other than English or Spanish, WellCare seeks to recruit staff Members who are bilingual in English plus one of those other languages.
WellCare does this even if the particular population is not of a size that triggers state agency mandates.

- **Diversity of Provider Network**
  - Providers are inventoried for their language abilities. 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 who 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 are provided by vendors with such expertise and 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 line for hearing-impaired services. CMS Health Plan’s Customer Service Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY number can be found on the Member identification card.

- **Provider Education**
  - WellCare’s Cultural Competency Program provides a checklist to assess the cultural competency of Providers’ offices

Providers must adhere to the Cultural Competency Program as highlighted above.

For more information about the Cultural Competency Program, registered Provider Portal users may access the full Cultural Competency Plan, cultural competency survey and Provider trainings on WellCare’s website at [www.wellcare.com/Florida/Providers](http://www.wellcare.com/Florida/Providers) under “Medicaid,” “Secure Login.” A paper copy may be obtained at no charge upon request by contacting Provider Services or a Provider Relations representative.

**Member Administrative Guidelines**

**Overview**
WellCare will make information available to Members on the role of the PCP, how to obtain care, what Members should do in an emergency or urgent medical situation, as well as Members’ rights and responsibilities. WellCare will convey this information through various methods including a Member Handbook.
**Member Handbook**

All newly enrolled Members can access the Member Handbook on CMS Health Plans website at [www.wellcare.com/en/Florida/Members/Medicaid-Plans/CMS/CMS-19](http://www.wellcare.com/en/Florida/Members/Medicaid-Plans/CMS/CMS-19) and may request a hard copy by contacting Member Services to request a copy of the handbook.

**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 CMS Health Plan, 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
- Brochures describing certain benefits not traditionally covered by Medicaid or Healthy Kids and other value-added items or services, if applicable

**Member Identification Cards**

Member identification cards are intended to identify CMS Health Plan Members, the type of plan they have and to facilitate their interactions with healthcare Providers.

Information found on the Member identification card may include the Member’s name, identification number, plan type, PCP’s name and telephone number, co-payment information, CMS 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.

Note: Members who have Medicare or other health insurance as their primary insurance are not required to choose a PCP with WellCare and they will receive an ID card stating that a PCP is not required.

**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 secure, online Provider Portal of the WellCare website at www.wellcare.com/Florida/Providers
• Access WellCare’s Interactive Voice Response (IVR) system
• Contact Provider Services

Providers will need their Provider ID number to access Member eligibility through the avenues listed above. 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 the Agreement for additional details.

Member Engagement
WellCare utilizes a number of engagement strategies to establish a relationship with its Members. Engagement begins with notification of Member enrollment. Notice of enrollment triggers an attempt to reach the CMS Health Plan Member or their guardian by phone to complete a comprehensive health assessment and to familiarize the Member and guardian with the plan benefits. Three attempts are made to contact the Member.

Assessments for Members
All CMS Health Plan Members are assigned a local Care Manager. Care managers are either licensed registered nurses or social workers. Care Managers complete assessments with the Member within the first 30 days of enrollment. Upon completion of the comprehensive assessment, a care plan is developed with input from the Member and his/her guardian, the Provider, and the CMS Health Plan Care Manager. The care plan is available for Providers to view via the Provider portal. Care Managers collaborate with the Provider to ensure the most successful care plan is developed and implemented to effect positive outcomes for the Member.

CMS Health Plan Member Rights and Responsibilities
Members have the right to:
• Be treated with courtesy and respect
• Have their dignity and privacy respected at all times
• Receive a quick and useful response to their questions and requests
• Know who is providing medical services and who is responsible for their care
• Know what member services are available, including whether an interpreter is available if they do not speak English
• Know what rules and laws apply to their conduct
• Be given information about their diagnosis, the treatment they need, choices of treatments, risks, and how these treatments will help them
• Say no any treatment, except as otherwise provided by law
• Be given full information about other ways to help pay for their health care
• Know if the provider or facility accepts the Medicare assignment rate
• To be told prior to getting a service how much it may cost them
• Get a copy of a bill and have the charges explained to them
• Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
• Receive treatment for any health emergency that will get worse if they do not get treatment
• Know if medical treatment is for experimental research and to say yes or no to participating in such research
• Make a complaint when their rights are not respected
• Ask for another doctor when they do not agree with their doctor (second medical opinion)
• Get a copy of their medical record and ask to have information added or corrected in their record, if needed
• Have their medical records kept private and shared only when required by law or with their approval
• Decide how they want medical decisions made if they can’t make them (advance directive)
• File a grievance about any matter other than a Plan’s decision about their services.
• To appeal a Plan’s decision about their services
• Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for them that is part of our Plan
• To file complaints or Appeals about The Plan or the care it provides
• To receive information about The Plan, its services, its practitioners and Providers, and Members rights and responsibilities
• To participate with practitioners in making decisions about their healthcare
• To a candid discussion of appropriate or medical necessary treatment options for their conditions, regardless of cost or benefit coverage
• To make recommendations regarding Member rights and responsibilities
• To be treated with respect and with due consideration for dignity and privacy

CMS Health Plan Members have the responsibility:
• Give accurate information about their health to their Plan and providers
• Tell their provider about unexpected changes in their health condition
• Talk to their provider to make sure they understand a course of action and what is expected of them
• Listen to their provider, follow instructions and ask questions
• Keep appointments or notify their provider if they will not be able to keep an appointment
• Be responsible for their actions if treatment is refused or if they do not follow the healthcare provider’s instructions
• Make sure payment is made for non-covered services they receive
• Follow healthcare facility conduct rules and regulations
• Treat healthcare staff with respect
• Tell us if they have problems with any healthcare staff
• Use the emergency room only for real emergencies
• Notify their Care Manager if they have a change in information (address, phone number, etc.)
• Have a plan for emergencies and access this plan if necessary for their safety
• Report fraud, abuse and overpayment
• To supply information (to the extent possible) that The Plan and its practitioners and Providers need in order to provide care
• To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible

Assignment of Primary Care Provider
Members enrolled in the CMS Health Plan must choose a PCP or they will be assigned to a PCP within our network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Member's healthcare needs from providing primary care services to coordinating referrals to specialists and Providers of ancillary or hospital services.

Changing Primary Care Providers
Members may change their PCP selection at any time by calling Customer Service. The requested change will be effective the first day of the following month of the request if the request is received after the tenth day of the current month.

Women’s Health Specialists
PCPs may also provide routine and preventive healthcare 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. CMS Health Plan Members have the right to obtain family planning services from any participating provider without prior authorization.

Hearing-Impaired, Interpreter and Sign Language Services
Hearing-impaired, interpreter and sign language services are available to CMS Health Plan Members through our Customer Service Department. PCPs should coordinate these services for CMS Health Plan Members and contact Customer Service if assistance is needed. For Provider Services telephone numbers, please refer to the Quick Reference Guide WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.
Section 3: 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 healthcare and services. The purpose of the QI Program is to promote quality of care and quality patient outcomes in service performance to our CMS Health Plan enrollees in accordance state and federal requirements.

Strategies are identified and activities implemented in response to findings. Our QI Program addresses the quality of clinical care and nonclinical 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 healthcare settings/services
- Cultural competency
- Quality of care/service
- Preventive health
- Service utilization
- Complaints/Grievances
- Network adequacy
- Appropriate service utilization
- Member and Provider satisfaction
- Components of operational service
- Regulatory/federal/state/accreditation requirements

Our QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Child Health Checkup (CMS 416 Measures), and/or medical record audits. Our Quality Improvement Committee is responsible for approving specific QI activities, (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective actions plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

Medical Records
Member medical records must be maintained timely, legible, current, detailed, and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to: medication lists, documentation of inpatient admissions, specialty consults appointment documentation, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed and dated by the Provider of service(s).

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to WellCare or its representatives without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. WellCare follows state and federal law regarding the retention of records remaining under the care, custody, and control of the physician or WellCare Health Plans, Inc.

Effective April 22, 2019
Children’s Medical Services Health Plan Provider Manual
Provider Services (toll free): 1-866-799-5321
healthcare Provider. Information from the medical records review may be used in the re-
credentialing process, as well as quality activities.

A key element in our partnership is the evaluation of the quality of care and services that we
deliver to our members, your patients. One of the most important ways we measure that quality
is through the Healthcare Effectiveness Data Information Set (HEDIS®). The HEDIS audit is an
annual requirement mandated by the National Committee for Quality Assurance (NCQA), our
state partners, and the Centers for Medicare & Medicaid Services (CMS). It is also part of your
provider contract with WellCare, which requires that you submit needed records at no charge
within three business days. Please refer to your contract for more information.

For more information regarding confidentiality of Member information and release of records,
refer to Section 8: Compliance.

The Member’s medical record is the property of the Provider who generates the record.
However, each Member or his or her representative is entitled to one free copy of his or her
medical record. Additional copies shall be made available to Members at cost.

Each Provider is required to maintain a primary medical record for each Member that contains
sufficient medical information from all Providers involved in the Member’s care to ensure
continuity of care. Providers must maintain a medical record for each member in accordance
with contract requirements, 42 CFR 431 and 42 CFR 456, and Rule 59G-1.054, F.A.C. The
medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or
  ethnicity, mailing address, home and work addresses and telephone numbers, employer,
  school, name and telephone numbers of emergency contacts (if no phone, contact
  name), consent forms, identify primary language spoken and any translation needs,
  identify communication assistance needed during the delivery of health care services,
  and guardianship information
- Date of data entry and date of encounter
- Late entries should include date and time of occurrence and date and time of
  documentation
- Provider identification by name and profession of the rendering Provider (e.g., M.D.,
  D.O., O.D.)
- Allergies and/or adverse reactions to drugs shall be noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses. For children,
  past medical history includes prenatal care and birth information, operations and
  childhood illnesses (e.g., documentation of chicken pox)
- Identification of current problems
- The consultation, laboratory and radiology reports filed in the medical record shall
  contain the ordering Provider’s initials or other documentation indicating review
- A current list of immunizations pursuant to 42 CFR 456
- Identification and history of nicotine, alcohol use, or drug/substance use disorder
- Documentation of reportable diseases and conditions to the local health department
  serving the jurisdiction in which the patient resides or Department of Public Health
  pursuant to 42 CFR 456
- Summaries of all emergency services and care
- Follow-up visits provided secondary to reports of emergency room care
• Hospital discharge summaries with appropriate, medically indicated follow up
• Advanced medical directives, for adults, including documentation the member was provided with written information concerning rights regarding advance directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether or not the member has executed an advance directive
• Documentation that Member has received the Provider’s office policy regarding office practices compliant to HIPAA
• Documentation regarding permission to share protected health information with specific individuals has been obtained
• Copies of any consent or attestation form used, or the court order for prescribed psychotherapeutic medication for a child under the age of 13
• Include the following items for services provided through telemedicine:
  o A brief explanation of the use of telemedicine in each progress note
  o Documentation of telemedicine equipment used for the particular Covered Services provided
  o A signed statement from the Member or the Member’s representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or onetime visit, as applicable to the service(s) provided
  o A review of telemedicine should be included in WellCare’s fraud and abuse detection activities
• Record is legible to at least a peer of the writer and written in standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer

A Member’s medical record shall include the following minimal detail for individual clinical encounters:
• Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening (EPSDT) services are addressed from previous visits
• Plan of treatment including:
  o Medication history, current medications prescribed, including the strength, amount and directions for use and refills
  o Therapies and other prescribed regimen
• Follow-up plans including consultation and referrals and directions, including time to return
• Education and instructions whether verbal, written, or via telephone

**OB/GYN Medical Records**
Medical records requirements and guidelines per current American College of Obstetrics and Gynecology standards:

The maternity chart will contain documentation of the following:
• Physical findings on each visit with a plan of treatment and follow-up for any abnormalities
• Nutritional assessment and counseling for all pregnant Members that includes:
  o Promotion of breastfeeding and the use of breast milk substitutes to ensure the provision of safe and adequate nutrition for infants
  o Offering a mid-level nutrition assessment as directed by clinical presentation
• Member education (childbirth/maternal care)
• Postpartum care within 56 days of delivery
• Family planning counseling and services for all pregnant women and mothers
• HIV testing/counseling is offered at the initial prenatal care visit and again at 28 weeks and 32 weeks:
  o All HIV positive women shall be reported to the local county health department and to Healthy Start, regardless of their Healthy Start screening score.
  o The provider will attempt to obtain a signed objection if a pregnant woman declines an HIV test and keeps this signed objection in the medical record; and
• All HIV infected women are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (Public Health Service Task Force Report entitled, Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States).
• Screening for Hepatitis B:
  o Providers must screen all pregnant Members during their first prenatal visit for Hepatitis B and again between 28 and 32 weeks for Members who test negative and are considered high-risk for Hepatitis B
• All HBsAg-positive women shall be reported to the local county health department and to Healthy Start, regardless of their Healthy Start screening score
  o The report should be made on the Department of Health Practitioner Disease Report Form (DH 2136). This form is available on WellCare’s website at www.wellcare.com/en/Florida/Providers/Medicaid/Forms
  o For more information, refer to the Required Screenings and Assessments for Pregnant Members job aid on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid
• Healthy Start – Pregnant women will receive a prenatal risk screening as part of their first prenatal visit. Provider will complete the Department of Health (DOH) Prenatal Risk Form (DH 3134), retain a copy in the Member’s medical record, forward a copy within 10 business days to the county health department where the screening was performed, and provide a copy to the Member. Providers will maintain documentation of Healthy Start screenings, assessments, findings and referrals in the Member’s medical record
• Florida hospitals contracting with WellCare must electronically file the Florida Healthy Start Infant (Postnatal) Risk Screening Instrument (DH Form 3135) and the Certificate of Live Birth with the CHD in the county where the infant was born within five business days of the birth. Birthing facilities not participating in the Department of Health electronic birth registration system must file the required birth information with the CHD within five business days of the birth, keep a copy of the completed DH Form 3135 in the Member’s medical record, and mail a copy to the Member
• Pregnant Members or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start screen, in the following ways:
  o If the referral is to be made at the same time the Healthy Start risk screen is administered, the Provider may indicate on the risk screening form that the Member or infant is invited to participate based on factors other than score
  o If the determination is made subsequent to risk screening, the Provider may refer the Member or infant directly to the Healthy Start care coordinator based on the assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance use disorder or domestic violence
• Providers refer all pregnant, breastfeeding and postpartum women to the local Women, Infants, and Children (WIC) office:
Providers provide a completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment)

- Hemoglobin or hematocrit (H&H)
- Any identified medical/nutritional problems
- Give a copy of the completed form to the Member
- Retain a copy of the completed form in the Member’s medical record

Provider Participation in the Quality Improvement Program

Network Providers are contractually required to cooperate with quality improvement activities. Providers are invited to participate in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, and feedback/input via satisfaction surveys.

Information regarding the QI Program, available upon request, includes a description of the QI Program and the annual evaluation of progress toward goal. WellCare evaluates the effectiveness of the QI Program on an annual basis. An annual report summarizes a review of completed and continuing QI activities that address the quality of clinical care and service, trending of measures to assess performance in quality of clinical care and quality of service, any corrective actions implemented, corrective actions which are recommended or in progress, and any modifications to the program. This report is available as a written document.

Member Satisfaction

On an annual basis, CMS Health Plan conducts a Member satisfaction survey of a representative sample of Members. Satisfaction with services, quality, and access is evaluated. The results are compared to our 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 healthcare 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 healthcare 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.

Risk Management/Patient Safety

The program includes, at a minimum, patient safety and risk mitigation practices and is designed to identify, investigate, analyze, evaluate, and prevent incidents that pose health and safety risk. The Risk Manager (RM) oversees the operation of the Risk Management Program, however; The WellCare Board of Directors (BOD) has the final authority for the program. The BOD assigns responsibility for the program’s operation to a Risk Manager (RM), certified in accordance with state regulations. The first and most critical step is identifying an incident and reporting this to the Risk Manager in the form of an incident report submission. All potential quality of care events and adverse incidents shall be reported by the Provider and/or Provider staff in all service delivery settings within 48 hours of the incident, to the RM within the Quality Improvement (QI) Department on the Incident Report Form located on our website at www.wellcare.com/Florida/Providers/Medicaid/Forms.
For additional assistance, contact WellCare’s RM at 1-813-206-3792.

Adverse incident reports must be completed in their entirety and need to include information, including the Member’s identity, description of the incident and outcomes, including current status of the Member.

The program relies on an incident reporting system to identify potential and/or actual quality of care events and/or adverse events that occur throughout our healthcare delivery system in order to select the most advantageous method of correcting, avoiding, reducing or eliminating risks. The incident reporting system is based upon the affirmative duty of all Providers and all agents and employees of WellCare to report injuries and adverse events.

**Potential Quality of Care (PQOC) incidents** are events where undesirable health outcomes for WellCare Members could have been avoided through additional treatment rendered by the Provider or through treatment delivered in a manner inconsistent with current medical standards of practice. They are classified in one of eight categories:

- Inadequate assessment/misdiagnose
- Delay or omission of care
- Medication issue
- Patient safety
- Post-op complications
- Procedural issue
- Readmission less than 30 days
- Death or serious disability

**Adverse Incidents** are events involving situations where an injury of a Member occurs during delivery of managed care plan Covered Services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as a result of any other action or lack thereof on the part of the staff of the Provider.

Examples of adverse incidents that result in the following and meet the above criteria are to be reported and can include but are not limited to:

1. Member death
2. Member brain damage
3. Member spinal damage
4. Permanent disfigurement
5. Fracture or dislocation of bones or joints
6. Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient’s case or patient’s preexisting physical condition
7. Any condition requiring surgical intervention to correct or control
8. Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
9. Any condition that extends the patient’s length of stay
10. Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility

Behavioral Health Potential Quality of Care and/or Critical Incidents are events that result in:
Death of a Member while the Member is in a facility operated or contracted by WellCare or in an acute care facility due to one of the following:
(1) Suicide
(2) Homicide
(3) Abuse
(4) Neglect
(5) An accident or other incident that occurs while the Member is in a facility operated or contracted by WellCare or in an acute care facility

- Member injury or illness – A medical condition that requires medical treatment by a licensed healthcare professional and which is sustained, or allegedly is sustained, due to an accident, act of abuse, neglect or other incident occurring while a Member is in a facility operated or contracted by WellCare or while the Member is in an acute care facility.
- Sexual battery while the Member is in a facility operated or contracted by WellCare or in an acute care facility; an allegation of sexual battery, as determined by medical evidence or law enforcement involvement, by:
  (1) A Member on another Member
  (2) An employee of WellCare, a Provider or a subcontractor, a Member
  (3) A Member on an employee of WellCare, a Provider or a subcontractor
- WellCare shall report if one or more of the following events occur:
  (1) Medication errors in an acute care setting
  (2) Medication errors involving children/adolescents in the care or custody of DCF
- Member suicide attempt – An act that clearly reflects an attempt by a Member to cause his or her own death while a Member is in a facility operated or contracted by WellCare or while the Member is in an acute care facility, which results in bodily injury requiring medical treatment by a licensed healthcare professional.
- Altercations requiring medical intervention – Any untoward or adverse event that requires medical intervention other than minimal first aid treatment occurring while a Member is in a facility operated or contracted by WellCare or while the Member is in an acute care facility.
- Member escape – To leave a locked or secured facility operated by WellCare
- Member elopement – To leave a facility operated or contracted by WellCare, an acute care facility, vehicle or supervised activity that would endanger a Member’s personal safety

Preventive Guidelines
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, tests for sexually transmitted diseases, and Pap smears

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 improvement activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from participating Providers and the Quality Improvement Committee. Improvement activities include (but are not limited to) distribution of information to Members and Providers, Member and Provider incentives, and telephonic outreach to Members with gaps in care. 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 adherence.

**Dual-Eligible Member HIV/AIDS Diagnosis Status Review Process**

In accordance with our contract with the Agency for Health Care Administration (AHCA), health plans are required to report HIV/AIDS status for all dual-eligible members (i.e.; enrolled in both Medicare and Medicaid in the state of Florida). Providers of dual-eligible Members are required to file with the health plan a signed written attestation confirming the Member’s HIV or AIDS diagnosis.

WellCare’s process for obtaining confirmation of dual-eligible Member HIV or AIDS diagnosis maintains strict confidentiality of our Member’s sensitive health information. Dual-eligible Members with a potential HIV/AIDS diagnosis are identified through a claims review process by select associates. In order to confirm the diagnosis, a dedicated Registered Nurse completes a review of available Member records. If a diagnosis can be confirmed through WellCare records, it is substantiated per a review by WellCare’s Senior Medical Director, who signs an attestation confirming the diagnosis.

If the diagnosis is unable to be confirmed through existing records, the nurse identifies the appropriate treating Provider and sends a certified letter and attestation template through a secure HIPAA and HITECH compliant mail service with a request that the attestation be completed and returned via a dedicated secure fax line. All Member information is stored in a secure electronic file with strict limitations to the documents. Once a Provider attestation is received confirming the Member’s diagnosis, the information is relayed to the Agency for Health Care Administration through a secure transmission process.

**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. Approval of the Clinical Practice Guidelines occurs through the Utilization Medical Advisory Committee who reports to Quality Improvement Committee. Clinical Practice Guidelines, to include preventive health guidelines, may be found on our website at [www.wellcare.com/Florida/Providers/Clinical-Guidelines](http://www.wellcare.com/Florida/Providers/Clinical-Guidelines).
The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90% of America’s health plans to measure performance on important dimensions of care and service. Annual HEDIS reporting is required by the state Medicaid programs and the health plan accreditation agencies. The tool comprises 88 measures across seven domains of care, including:

1. Effectiveness of care
2. Access and availability of care
3. Satisfaction with the care experience
4. Utilization and risk adjusted utilization
5. Relative resource use
6. WellCare descriptive information
7. Measures collected using electronic clinical data systems

A key element in our partnership is the evaluation of the quality of care and services that we deliver to our Members, your patients. One of the most important ways we measure that quality is through the Healthcare Effectiveness Data Information Set (HEDIS®). All HEDIS data reported is audited and certified by an NCQA designated auditing firm as required by accreditation bodies, our state partners, and the Centers for Medicare & Medicaid Services (CMS). It is also part of your provider agreement with WellCare, which requires that you submit needed records at no charge within three business days. Please refer to the contract for more information.

**Web Resources**
WellCare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on our website. Please check our website frequently for the latest news and updated documents at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid).
Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM)

Utilization Management

Overview
WellCare’s Utilization Management (UM) Program is designed to meet contractual requirements with federal regulations, while providing Members access to high-quality, cost-effective Medically Necessary care. For purposes of this section, terms and definitions may be contained within this section, within Section 13: Definitions of this Manual, or both.

The focus of the UM program is on:

• Evaluating requests for services by determining the Medical Necessity, efficiency, appropriateness and consistency with the Member’s diagnosis and level of care required
• Providing access to medically appropriate, cost-effective healthcare services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers
• Reducing overall expenditures by developing and implementing programs that encourage preventive healthcare behaviors and Member partnership
• Facilitating communication and partnerships among Members, families, Providers, delegated entities and WellCare in an effort to enhance cooperation and appropriate utilization of healthcare services
• Reviewing, revising and developing medical coverage policies to ensure Members have appropriate access to new and emerging technology
• Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical healthcare services

Medically Necessary Services
The determination of whether a covered benefit or service is Medically Necessary requires compliance with the requirements established in Florida Administrative Code, Chapter 59G-1.010 and WellCare’s agreement with the Agency. To be Medically Necessary or a Medical Necessity, a covered benefit shall:

(a) Meet the following conditions:
   • Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
   • Be individualized, specific, and consistent with symptoms or confirm diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs
   • Be consistent with generally accepted professional medical standards as determined by the program, and not be experimental or investigational
   • Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
   • Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker or the Provider

(b) “Medically Necessary” or “Medical Necessity” for inpatient hospital services requires that
those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a Provider has prescribed, recommended or approved medical or allied care, goods or services does not, in itself, make such care, goods or services Medically Necessary or a Medical Necessity or a Covered Service.

In accordance with 42 CFR 440.230, each Medically Necessary service must be sufficient in amount, duration and scope to reasonably achieve its purpose.

WellCare’s UM program includes components of Prior Authorization and prospective, concurrent, and retrospective review activities. Each component is designed to provide for the evaluation of healthcare and services based on CMS Health Plan Members’ 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 UM activities for issuing denials of coverage, services or care. WellCare does not provide financial incentives to encourage or promote underutilization.

Criteria for UM Decisions
WellCare’s UM program uses nationally recognized review criteria based on sound scientific medical evidence. Physicians with an unrestricted license in the state of Florida and professional knowledge and/or clinical expertise in the related healthcare specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:
- InterQual™
- WellCare Clinical Coverage Guidelines
- Medical Necessity
- State Contract
- State Provider Handbooks, as appropriate
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment

The clinical reviewer and/or Medical Director involved in the UM process apply Medical Necessity criteria in context with the Member’s individual circumstance and the capacity of the local Provider delivery system. When the above criteria do not address the individual Member’s needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.

The review criteria and guidelines are available to the Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting the Utilization Management Department via Provider Services. The phone number is listed on the Quick Reference Guide which may be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.
**Utilization Management Process**

The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Prior Authorizations
- Concurrent review
- Retrospective review

Decision and notification time frames are determined by either National Committee for Quality Assurance (NCQA®) requirements, contractual requirements or a combination of both.

WellCare forms for the submission of notifications and authorization requests can be found on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid/Forms](http://www.wellcare.com/Florida/Providers/Medicaid/Forms).

**Notification**

Notifications are communications to WellCare with information related to a service rendered to a Member or a Member’s admission to a facility. Notification is required for:

- Prenatal services. This enables WellCare to identify pregnant Members for inclusion into the care coordination program for pregnant Members. OB Providers are required to notify WellCare of pregnancies via fax using the *Prenatal Notification Form* as soon as possible after the initial visit. This process will expedite care management and claims reimbursement
- A Member’s admission to a hospital. This enables WellCare to log the hospital admission and follow up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone and include Member demographics, facility name and admitting diagnosis
- WellCare requires Providers to notify WellCare by the next business day of a Member’s inpatient admission to a hospital. Failure to notify WellCare of admission by the next business day is grounds for inpatient authorization or claim denial.

**Referrals**

For an initial referral, WellCare does not require authorization as a condition of payment. Certain diagnostic tests and procedures considered by WellCare to be routinely part of an office visit may be conducted as part of the initial visit without an authorization.

**Prior Authorization**

Prior Authorization allows for efficient use of Covered Services and ensures that Members receive the most appropriate level of care, within the most appropriate setting. Prior Authorization may be obtained by the Member’s PCP, treating specialist or facility.

Reasons for requiring Prior Authorization may include:

- Review for Medical Necessity
- Appropriateness of rendering Provider
- Appropriateness of setting
- Case and disease management considerations

Prior Authorization is **required** for select elective or Non-Emergency Services as designated by WellCare. Guidelines for Prior Authorization requirements by service type may be found in the *Quick Reference Guide* on WellCare’s website at [www.wellcare.com/QuickReferenceGuide](http://www.wellcare.com/QuickReferenceGuide).
Some Prior Authorization guidelines to note are:

- The Prior Authorization request should include the diagnosis to be treated and the CPT® Code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised Authorization is not required.
- An Authorization may be given for a series of visits or services related to an episode of care. The Authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.
- Failure to obtain authorization prior to an elective or Non-Emergency Service is grounds for denial of a post-service authorization request or claim submission for services that did require an authorization, but was not received by WellCare.

Providers are required to obtain authorization of any Medically Necessary service to Members under the age of 21 years when the service is not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

- The process for obtaining this authorization is as follows:
  - The authorization request is received from the Provider
  - A non-clinical associate will log the request and send to the reviewer.
  - The reviewer will review the request against the benefit plan and the clinical criteria.
  - If services meet the benefit plan and/or the appropriate criteria, the service will be authorized and Provider will be notified by fax or phone.
  - If not met, the request will be sent to the Medical Director or other appropriate reviewer for review of Medical Necessity.
  - If medical director or other reviewer approves the request, the service will be authorized and Provider will be notified by fax or phone.
  - If medical director or other reviewer denies the request, the Provider will be notified and a Notice of Adverse Benefit Determination (denial letter) will be sent to the Member and Provider.

The attending physician or designee is responsible for obtaining the Prior Authorization of the elective or non-urgent admission. Refer to the Quick Reference Guide which may be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid for a list of services requiring Prior Authorization.

**Oncology Pre-Authorization**
WellCare has a quality review program for medical oncology and radiation therapy procedures for CMS Health Plan Members.

WellCare is committed to ensuring you receive information about process changes that may affect your office operations. These programs are designed to improve care quality and patient safety and reduce utilization and expenditures by applying evidence-based clinical criteria.

WellCare partners with a specialty benefits manager, HealthHelp, to administer the quality review process. All requests for the tests and procedures listed below go through HealthHelp except services rendered in an emergency or inpatient setting.
• **Medical Oncology**: Chemotherapy, hormone therapy, biologics, prophylactics
• **Radiation Therapy**: 2D3D, brachytherapy, stereotactic, proton beam, neutron beam, IMRT

**NOTE**: A complete list of procedure codes requiring a quality review tracking number can be found at [portal.healthhelp.com/wellcare](http://portal.healthhelp.com/wellcare).

**The HealthHelp Program**
HealthHelp provides a quality review program that improves care quality and increases the efficiency of healthcare expenditures by providing expert peer-to-peer consultation and the latest evidence-based medical criteria for reviewing medical oncology and radiation therapy procedures. The HealthHelp quality review process involves collecting relevant clinical information from the ordering/treating physician’s office and reviewing this information alongside current evidence-based guidelines. If the requested service does not meet evidence-based guidelines and Medical Necessity Criteria, a HealthHelp oncologist or other specialist will initiate a provider-to-provider consultation with the requesting physician to discuss the appropriateness of the treatment/test requested, patient safety, and possible alternatives.

When ordering medical oncology and radiation therapy procedures, you or your office staff will need to submit the quality review request using a web-based ordering system, fax or phone. Requests will be reviewed against evidence-based guidelines and Medical Necessity criteria, and a quality review tracking number will be issued as appropriate.

**Program Information**
Educational materials and program implementation information are featured on WellCare’s website at [portal.healthhelp.com/wellcare](http://portal.healthhelp.com/wellcare). Also, additional information about the new quality review process will be provided in HealthHelp’s 30-minute webinars, which contain helpful information and tips, complete procedure code lists, fax request forms, and HealthHelp contact information. To request a webinar, please contact HealthHelp program support at 1-800-546-7092.

**Submission Requests**
Ordering physicians may request a quality review tracking number for medical oncology and radiation therapy services using one of the following three methods:

- **Web**: [portal.healthhelp.com/wellcare](http://portal.healthhelp.com/wellcare)
- **Phone**: 1-888-210-3736
- **Fax**: 1-888-210-3769 (form can be obtained at the above website)

**NOTE**: The most efficient method for obtaining a quality review tracking number is through the web. Please contact HealthHelp program support at 1-800-546-7092 if you need assistance with setting up web access.

HealthHelp representatives are available Monday–Friday from 7 a.m. to 10 p.m. Central. After-hours requests may be submitted by fax or web portal. Staff will be available 24/7 to process the authorization requests.

For a Medically Necessary request that requires **immediate handling** due to an unforeseen illness, injury, or condition that could affect the patient’s condition, a **phone call to 1-888-210-3736 is the fastest way to process your urgent request**. If you choose to fax your urgent
request, please ensure that legible contact information is included for the ordering physician/designee stating how he or she may be reached within the next 24 hours in case additional clinical information is needed to complete the review.

All urgent requests will be handled within the state-specific or federal program-mandated expedited time frames, as appropriate. HealthHelp strives to complete all expedited requests for review within 24 hours of the request’s receipt, unless a more stringent time frame is mandated by specific state regulations.

For questions or information regarding general WellCare policy and procedures, visit the WellCare website at www.wellcare.com. You can also contact a WellCare representative at 1-855-538-0454.

**Concurrent Review**

Concurrent review activities involve the evaluation of a continued hospital, Long-Term Acute Care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review clinician follows the clinical status of the Member through telephonic or on-site chart review and communication with the attending physician, hospital UM, case management staff or hospital clinical staff involved in the Member’s care.

- Concurrent review is initiated as soon as we are notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:
  - Ensure that services are provided in a timely and efficient manner
  - Make certain that established standards of quality care are met
  - Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate
  - Complete timely and effective discharge planning
  - Identify cases appropriate for case management or care coordination

The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed clinicians under the direction of the WellCare Medical Director.

To ensure the review is completed timely, Providers must submit notification and clinical information on the next business day after the admission, as well as upon request of the WellCare review clinician. Failure to submit necessary documentation for concurrent review may result in nonpayment.

**Discharge Planning**

Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. Discharge plans from behavioral health inpatient admissions will be monitored to ensure that they incorporate the Member’s needs for continuity in existing behavioral health therapeutic relationships. Behavioral healthcare Providers should assign a mental health targeted case manager to oversee the care given to the Member to ensure a smooth transition to a lower level of care. The concurrent review clinician works with the attending physician, hospital discharge planner, family members,
guardians, ancillary Providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Member to the appropriate level of care. An inpatient review nurse may refer an inpatient Member with identified complex discharge needs to transitional care management for in-facility outreach.

**Transitional Care Management**

The Transitional Care Management Department's role is designed to identify and outreach to Members in the hospital and/or recently discharged who are at high risk for readmission to the hospital. The program is a twofold process; it may begin with a pre-discharge screening to identify Members with complex discharge needs, and to assist with the development of a safe and effective discharge plan. Post-discharge, the process focus is to support recently discharged Members through short-term case management to meet immediate needs that allows the Member to remain at home and reduce avoidable readmissions.

The care manager’s work includes, but is not limited to: (a) screening for Member needs; (b) education; (c) care coordination; (d) medication reconciliation; and (e) referrals to community-based services. Timely follow up is critical to quickly identify and alleviate any care gaps or barriers to care.

The goal of the Transitional Care Program is to ensure that complex, high-risk Members are discharged with a safe and effective plan in place, to promote Members’ health and well-being and reduce avoidable readmissions. The transitional care manager will coordinate with the Member’s designated Care Manager.

**Retrospective Review**

A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews which WellCare may perform:

- **Retrospective review initiated by WellCare**
  - WellCare requires periodic documentation including, but not limited to, the medical record (UB and/or itemized bill) to complete an audit of the Provider-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to WellCare to support accurate coding and claims submission.

- **Retrospective review initiated by Providers**
  - 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 30 calendar days of receipt of a request for a UM 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 14 calendar days of the post-service request.

The Member or Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the Utilization Management Department via Provider Services.
Refer to the Quick Reference Guide, which may be found on WellCare's website at www.wellcare.com/Florida/Providers/Medicaid.

Peer-to-Peer Reconsideration of Adverse Benefit Determination
In the event of an adverse determination following a Medical Necessity review, peer-to-peer discussion is offered to the attending or ordering physician via fax notification. The attending or ordering physician is provided a toll-free number to the Medical Director Hotline to request a discussion with the WellCare medical director who made the denial determination. Peer-to-peer discussion is offered within 24 hours for prior authorization requests and seven calendar days for inpatient requests from the decision date.

The review determination notification contains instructions on how to request a peer-to-peer discussion process.

Services Requiring No Authorization
WellCare has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of Members including:

- Certain diagnostic tests and procedures considered by WellCare to routinely be part of an office visit, and plain film X-rays
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a Clinical Laboratory Improvements Amendments (CLIA) waiver do not require Prior Authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
  - Reproductive laboratory tests
  - Molecular laboratory tests
  - Cytogenetic laboratory tests
- Certain tests described as CLIA-waived may be conducted in the physician’s office if the Provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to WellCare

All services performed without Prior Authorization are subject to retrospective review by WellCare.

WellCare Notice of Adverse Benefit Determination
An adverse benefit determination is an action taken by the CMS Health Plan to deny a request for services. In the event of an adverse benefit determination, we will notify the Member and the requesting Provider in writing of the determination. The notice will contain the following:

- The action we have taken or intend to take
- The reason(s) for the action
- The Member’s right to appeal
- The Member’s right to request a state hearing or external review
- Procedures for exercising Member’s rights to appeal or file a grievance
- Circumstances under which expedited resolution is available and how to request it
- The Member’s rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services
**Second Medical Opinion**
A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any Member of the healthcare team, a Member, parent(s) and/or guardian(s) or a social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the Member by a qualified healthcare professional within network, or a non-participating Provider if there is not a participating Provider with the expertise required for the condition.

In accordance with Florida Statute 641.51, the Member may elect to have a second opinion provided by a non-contracted Provider. We will pay the amount of all charges which are usual, reasonable and customary in the community for second opinion services performed by a physician not under contract with WellCare, but may require the Member to be responsible for up to 40% of such amount. WellCare may require that any tests deemed necessary by a non-contracted Provider be conducted by a participating WellCare Provider.

**Individuals with Special Healthcare Needs**
Individuals with special healthcare needs (ISHCN) are adults and children/adolescents who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. Factors include: (a) individuals with Intellectual Disabilities or related conditions; (b) individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; (c) individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and (d) children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to placement in foster care.

Physicians who render services to Members who have been identified as having chronic or life-threatening conditions should:
- Allow the Members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the Member’s condition or needs:
  - To obtain a standing authorization, the Provider should complete the Outpatient Authorization Request Form (located on WellCare’s website) and document the need for a standing authorization request under the pertinent clinical summary area of the form
  - The authorization request should outline the plan of care including the frequency, total number of visits and the expected duration of care
- Coordinate with WellCare 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 healthcare services furnished to the Member
- Ensure that Members requiring specialized medical care over a prolonged period of time have access to a specialty care Provider
  - Members will have access to a specialty care Provider through standing authorization requests, if appropriate
Service Authorization Decisions

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Extension</th>
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</thead>
<tbody>
<tr>
<td>Standard Pre-service</td>
<td>7 calendar days</td>
<td>4 calendar days</td>
</tr>
<tr>
<td>Expedited Pre-service</td>
<td>2 days</td>
<td>1 day</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>24 hours</td>
<td>48 hours</td>
</tr>
<tr>
<td>Post-service</td>
<td>30 calendar days</td>
<td>15 calendar days</td>
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</table>

**Standard Service Authorization**
WellCare will provide a Service Authorization decision as expeditiously as the Member’s health condition requires and within state-established time frame which will not exceed seven calendar days. WellCare will fax an authorization response to the Provider fax number(s) included on the authorization request form. An extension may be granted for an additional four calendar days if the Member or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member’s best interest.

**Expedited Service Authorization**
In the event the Provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the Member’s life or health, WellCare will make an expedited authorization determination and provide notice within **two days** of the request. An extension may be granted for an additional business day if the Member or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member’s best interest. **Requests for expedited decisions for Prior Authorization should be requested by telephone**, not fax or WellCare’s secure, online Provider Portal. Please refer to the *Quick Reference Guide* to contact the UM Department via Provider Services, which may be found on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid).

Members and Providers may file a verbal request for an expedited decision.

**Urgent Concurrent Authorization**
An authorization decision for services that are ongoing at the time of the request, and that are considered to be urgent in nature, will be made within 24 hours of receipt of the request. An extension may be granted for an additional 48 hours.

**Emergency/Urgent Care and Post-Stabilization Services**
Emergency services are not subject to Prior Authorization requirements and are available to Members 24 hours a day, seven days a week. Urgent care services should be provided within one day. See *Section 13: Definitions* for definitions of “emergency” and “urgent.”

Post-stabilization services are services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve, or resolve the Member’s condition. Post-stabilization services are covered without Prior Authorization up to the point WellCare is notified that the Member’s condition has stabilized.

Emergency service Providers shall make a reasonable attempt to notify WellCare within 24 hours of the Member’s presenting for emergency behavioral health services.

Mobile crisis assessment and intervention for Members in the community may be provided in lieu of emergency behavioral healthcare.
**Continuity of Care**

Members in active treatment may continue care when such care is Medically Necessary, through the completion of treatment of a condition for which the Member was receiving at the time of the termination or until the Member selects another treating Provider, for a minimum of sixty days, not to exceed six months from a not-for-cause terminated provider.

WellCare will allow pregnant Members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a not-for-cause terminated treating Provider until completion of postpartum care.

For continued care under this provision, WellCare and the terminated Provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

**Transition of Care**

CMS Health Plan will honor any written documentation of prior authorization of ongoing covered services for a maximum of 180 days after the effective date of enrollment for initial transition of CMS Health Plan Members or 90 days for all post-transition new enrollments, or until the enrollee's PCP or behavioral health service provider (as applicable to medical care or behavioral healthcare services, respectively) reviews the enrollee's plan of care, whichever comes first.

The following services may extend beyond the 90-day transition of care period, and WellCare shall continue the entire course of treatment with the Member's current Provider as described below:

- **Prenatal and postpartum care** – WellCare shall continue to pay for services provided by a pregnant Member's current Provider for the entire course of her pregnancy, including the completion of her postpartum care (six weeks after birth), regardless of whether the Provider is in WellCare's network

- **Transplant services (through the first year post-transplant)** – WellCare shall continue to pay for services provided by the current Provider for one year post-transplant, regardless of whether the Provider is in WellCare's network

- **Oncology (radiation and/or chemotherapy services for the current round of treatment)** – WellCare shall continue to pay for services provided by the current Provider for the duration of the current round of treatment, regardless of whether the Provider is in WellCare's network

- **Full-course therapy Hepatitis C treatment drugs**

During the transition of care period, authorization is not required for certain Members with previously approved services by the state or another managed care plan. We will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside WellCare's network until such time as WellCare can reasonably transfer the Member to a service and/or network Provider without impeding service delivery that might be harmful to the Member’s health. However, notification to WellCare is necessary to properly document these services and determine any necessary follow-up care.
WellCare will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider when Members move to a new health plan for transition of care needs.

When we becomes aware that a covered Member will be disenrolled from CMS Health Plan and will transition to a Medicaid Fee-For-Service (FFS) program or another managed care plan, the CMS Health Plan Case Manager who is familiar with that Member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program.

If a Provider receives an adverse claim determination which they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals department with documentation of approval from agency or previous managed care organization for reconsideration. Refer to the Quick Reference Guide for the Appeals department contact information which may be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

**Authorization Request Forms**

WellCare requests Providers use the standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to their request, including:

- **Inpatient Authorization Request Form** is used for services such as planned elective/non-urgent inpatient, observation, and skilled nursing facility and inpatient rehabilitation authorizations
- **Outpatient Authorization Request Form** is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, radiation therapy, out-of-network services
- **DME Ancillary Authorization Services Request Form** is used for services such as Durable Medical Equipment (DME),
- **End Stage Renal Disease Form** is used for services related to End Stage Renal Disease, kidney transplants, and dialysis,
- **Skilled Therapy Services (OT/PT/ST) Prior Authorization Form** is used for outpatient therapies including Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST).

All Ancillary Authorization Request forms for non-urgent/elective ancillary services should be submitted via fax to the number listed on the form.

To ensure timely and appropriate claims payment, all forms must:

- Have all required fields completed
- Be typed or printed in black ink for ease of review
- Contain a clinical summary or have supporting clinical information attached

Incomplete forms are not processed and will be returned to the requesting Provider. If Prior Authorization is not granted, all associated claims will not be paid.

Providers must immediately notify WellCare of a Member’s pregnancy. A Prenatal Notification Form should be completed by the OB/GYN or Primary Care Provider during the first visit and
faxed to WellCare as soon as possible after the initial visit. Notification of OB services enables WellCare to identify Members for inclusion into the Prenatal Program and/or Members who might benefit from WellCare’s High Risk Pregnancy Program, and for reporting pregnancies to DCF.

All forms are located on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid/Forms. All forms should be submitted via fax to the number listed on the form.

In no instance may the limitations or exclusions imposed by WellCare be more stringent than those specified in the Florida Medicaid Rules, Policies, and Handbooks.

**Delegated Entities**
WellCare delegates some utilization management activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of WellCare and the delegated entities. The agreement must be approved by DOH, prior to implementation.

Delegation of select functions may occur only after an initial audit of the utilization management activities has been completed and there is evidence that WellCare’s delegation requirements are met. These requirements include:
- A written description of the specific utilization management delegated activities
- Semi-annual reporting requirements
- Evaluation mechanisms
- Remedies available to WellCare if the delegated entity does not fulfill its obligations

On an annual basis, or more frequently as needed, audits of the delegated entity are performed to ensure compliance with WellCare’s delegation requirements. For more information on Delegated Entities, refer to Section 9: Delegated Entities.

**Care Management Program**

CMS Health Plan offers comprehensive care management services to facilitate health status assessment, care planning, and advocacy to improve health and quality of life outcomes for its Members and their guardians. The CMS Health Plan Care Management Program is built around every Member’s unique healthcare needs to assess their needs, facilitate their access to care, and help them when they need CMS Health Plan:
- Identify
- Reach
- Engage
- Assess
- Care
- Help
CMS Health Plan understands that care management must complement primary care, specialty care, behavioral health services, ancillary services, outpatient and inpatient services. The Plan’s care management services are specifically designed to:

- Foster the relationship between a Member and his or her providers.
- Empower Members and their guardians to take control of their health by initiating and reinforcing healthy behaviors.
- Help Members and their guardians obtain timely, effective, quality and culturally-sensitive care and minimize gaps in care.
- Assist Members and their guardians with understanding and accessing their benefits to improve Member outcomes.

The Plan’s multidisciplinary care management team includes registered nurses (RNs) and licensed behavioral health clinicians who perform comprehensive assessments of the Members’ health status, develop an individualized person and family-centered care plans with agreed-upon goals, monitor outcomes and update the care plans as necessary. Our CMS Health Plan Care Managers share the care plans and work collaboratively with Providers, schools and other relevant agencies to coordinate and facilitate access to care and services when needed. Care plans are available by mail or fax and can be accessed on the Provider Portal. CMS Health Plan requests that Providers participate as active members of the interdisciplinary care team for those Members that are engaged in case and disease management programs.

All children enrolled in the CMS Health Plan are enrolled in Care Management including children with:

- **Catastrophic Conditions** – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas.
- **Multiple Chronic Conditions** – Multiple comorbidities such as diabetes or multiple intricate barriers to quality healthcare, i.e., AIDS or a comorbid behavioral health and complex medication condition.
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up.
- **Complex Needs** – Children receiving skilled nursing facility services, Medical Foster Care Services, private duty nursing, and prescribed pediatric extended care.
- **Special Healthcare Needs** – Children who have serious medical or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities.
- **At Risk Populations:** Children in the State Inpatient Psychiatric Program (SIPP) as well as those with involvement, or at risk for involvement, with the justice system, DJJ or DCF.

In addition to the covered services, CMS Health Plan offers and coordinates access to quality enhancements (QEs). It is our goal to promote positive health outcomes by offering the following quality enhancements/services.

- **Children’s Programs:** First Year of Life (FYOL) is a wellness program targeted toward members from birth to 15 months. The Plan will authorize covered services recommended by the Early Intervention Program when medically necessary. CMS Health Plan will offer annual training to providers that promote proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.
• Domestic Violence: CMS Health Plan ensures that PCPs screen members for signs of domestic violence and shall offer referral services to applicable domestic violence prevention community agencies.

• Pregnancy Prevention: CMS Health Plan conducts regularly scheduled pregnancy prevention programs and makes a good faith effort to involve members in existing community pregnancy prevention programs, such as the Abstinence Education Program. The programs target teen members, but are open to all members, regardless of age, gender, pregnancy status or parental consent.

• Prenatal/Postpartum Pregnancy Programs: CMS Health Plan provides regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant members and postpartum Members who are not in compliance with the plan’s prenatal and postpartum programs. CMS Health Plan coordinates our efforts with local Healthy Start Care Coordinator/Care Managers to prevent duplication of services.

• Behavioral Health Programs: CMS Health Plan provides outreach to homeless and other populations of members at risk of justice system involvement, as well as those members currently involved in this system, to assure that services are accessible and provided when necessary.

• Other Programs and Services: CMS Health Plan actively collaborates with community agencies and organizations, including County Health Departments, local Early Intervention Programs and local school districts in offering services.

Disease Management Program

Disease management is a component of Care Management. Clinically trained Care Managers support Members with targeted chronic conditions. CMS Health Plan’s primary role is to give its Members and their guardians the education and the tools that they need to take control of their health. To accomplish this, CMS Health Plan identifies Members with chronic conditions and provides education and health coaching to empower them to make behavior changes and self-manage their condition(s).

To support the Members’ relationship with their physicians, we will provide the disease management plan of care through our Provider Portal. Our physician engagement strategies are designed to give Providers feedback and information about their patients’ progress as well as any care gaps or risk management issues.

The Disease Management Program targets the following conditions:

- Asthma
- Diabetes
- Cancer
- Sickle cell anemia
- Phenylketonuria (PKU) and other metabolic conditions
- Developmental disabilities, including autism
- Rare congenital conditions including cleft lip/palate, spina bifida, congenital heart disease;
- Mental health including ADHD and severe emotional disturbance;
- Substance abuse;
- Hemophilia;
- HIV/AIDS; and
- Children with special healthcare needs.

CMS Health Plan disease management process will consist of:

- Identification: Identify and outreach to all Members to perform an initial screening to determine who has chronic conditions and may benefit from disease management program(s)
- Assessment and Plan: Assessment completed and individualized disease management plan of care developed
- Education and Support: Develop a disease management focused care plan in collaboration with the Member and guide them through the disease management milestones
- Program Evaluation: Evaluate the effectiveness of the disease management program, both from a patient-centered and population management perspective

Disease Management Programs employ evidence-based Clinical Practice Guidelines. Disease-specific Clinical Practice Guidelines adopted by CMS Health Plan may be found on our website at [www.wellcare.com/Florida/Providers/Clinical-Guidelines](http://www.wellcare.com/Florida/Providers/Clinical-Guidelines). Interventions are individualized by level of need.

CMS Health Plan disease management offerings employ innovative biometric monitoring solutions for high-risk Members diagnosed with CHF, COPD, CAD and diabetes. Biometric measurement devices provide critical, actionable data to the Member’s Care Manager as well as to their Provider regarding biometric values, such as weight, glucose levels or blood pressure readings, combined with Member-reported symptom data specific to their condition.

CMS Health Plan makes education available to Providers and Members regarding their health conditions on both the Member and Provider Portals which can be accessed through the website at [www.wellcare.com/Florida/Providers](http://www.wellcare.com/Florida/Providers).
Section 5: Claims

Overview
The focus of WellCare’s Claims department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for Providers to access a representative in its Customer Service Department. For more information, refer to the Quick Reference Guide, which may be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

For Providers who are unaccustomed to submitting claims, WellCare provides detailed claims’ submission procedures on its website. The Florida Medicaid Provider Resource Guide on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid provides information regarding how to submit both paper and electronic claims.

The claims submission address, telephone numbers for contacting Provider Services, how to file a claims dispute, and authorization information are located on the Quick Reference Guide which can be accessed on WellCare’s website.

Additional information regarding reimbursement policies and Claims Companion Guides are located on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid/Claims.

Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process

WellCare (in partnership with PaySpan) has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

Once registered, this no-cost secure service offers Providers a number of options for viewing and receiving remittance details. ERAs can be imported directly into practice management or patient accounting system, eliminating the need to rekey remittance data.

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will no longer receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from PaySpan’s website, once registration is completed.

Providers can register using PaySpan’s enhanced Provider registration process at payspan.com.
PaySpan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the Web at payspanhealth.com.

Timely Claims Submission
Unless otherwise stated in the Provider Participation Agreement (the Agreement), Provider must submit claims (initial and corrected) within six months from the date of service for outpatient services and the date of discharge for inpatient services. When WellCare is secondary, provider must submit claims within 90 days from the primary payers EOB date, except for Medicare Crossover. The limit for Medicare claims crossing over to Medicaid is the greater of 36 months from the date of service, or 12 months from Medicare EOB date. Unless prohibited by federal
law or the Centers for Medicare & Medicaid Services (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 Explanation of Benefits (EOB)/claim(s) in question, prior submission bill dates; and WellCare product name or line of business
- Certified mail receipt

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

- Strategic National Implementation Process (SNIP) Rejection Letter; and
- A copy of the Provider’s billing screen

Tax Identification (TIN) and National Provider Identifier (NPI) Requirements
WellCare requires the payer-issued Tax ID and NPI on all claims submissions. WellCare will reject claims without the Tax ID and NPI, with the exception of atypical Providers. Atypical Providers must pre-register with WellCare before submitting claims to avoid NPI rejections. More information on NPI requirements, including HIPAA’s NPI Final Rule Administrative Simplification, is available on the CMS website at www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html.

Taxonomy
Providers are required to submit claims with the correct taxonomy code consistent with Provider’s specialty and services being rendered in order for appropriate adjudication. WellCare may reject the claim if the taxonomy code is incorrect or omitted.

Pre-Authorization number
If a pre-authorization number was obtained, Providers 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 SNIP guidelines.

If a claim is rejected for lack of compliance with WellCare’s claim and encounter submission requirements, a new claim should be submitted within timely filing limits.

Claims Submission Requirements
WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare requires all diagnosis coding to be ICD-10-CM, or its successor, as mandated by CMS. Refer to Compliance section for additional information. In addition, the CPT-4 coding and/or Healthcare
Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the Provider must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

WellCare tracks billing codes and Providers who continue to apply incorrect coding rules. Providers will be educated on the proper use of codes as part of the Retrospective Review process. Should a Provider continue to repeat the inappropriate coding practice, the Provider will be subject to an adverse action.

When presenting a claim for payment to WellCare, the Provider is indicating an understanding that:

- The Provider has an affirmative duty to supervise the provision of, and be responsible for, the Covered Services claimed to have been provided
- To supervise and be responsible for preparation and submission of the claim
- To present a claim that is true and accurate and that is for WellCare Covered Services that:
  - Have actually been furnished to the Member by the Provider prior to submitting the claims
  - Are Medically Necessary

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. The 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. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member Expenses and/or non-Covered Services. For more information on paper submission of claims, refer to the Quick Reference Guide WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid. For more information on Covered Services under WellCare’s Florida Medicaid plans, refer to WellCare’s website at www.wellcare.com. For more information on claims submission requirements, refer to Florida Statute 641.3154.

International Classification of Diseases (ICD)

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). WellCare utilizes ICD for diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor.

Information on the ICD-10 transition and codes can also be found at [www.wellcare.com/Florida/Providers/ICD10-Compliance](http://www.wellcare.com/Florida/Providers/ICD10-Compliance).

**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 5010A 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/Florida/Providers/Medicaid/Claims](http://www.wellcare.com/Florida/Providers/Medicaid/Claims).

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 clearinghouse(s), for information on the unique WellCare Payer Identification (Payer ID) numbers used to identify WellCare on electronic claims submissions, or to contact WellCare’s EDI team, refer to the *Provider Resource Guide*, which may be found on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid).

**HIPAA Electronic Transactions and Code Sets**
*HIPAA Electronic Transactions and Code Sets* is a federal mandate that requires healthcare 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 DDE transactions.

For more information on EDI implementation with WellCare, refer to the *WellCare Companion Guides* on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid/Claims](http://www.wellcare.com/Florida/Providers/Medicaid/Claims).

**Paper Claims Submissions**
For timelier processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties as specified in the Agreement. For assistance in creating an EDI process, contact WellCare’s EDI team by referring to the *Quick Reference Guide* on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid).

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 an original (red ink on white paper) claim forms
- Any missing, illegible, 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 Clean Claims submission:
  - **The information must be aligned within the data fields and must be:**
    - On an original red ink on white paper claim forms
    - Typed. Do not print, handwrite, or stamp any extraneous data on the form
    - In black ink
    - In 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

CMS Fact Sheet about UB-04

CMS Fact Sheet about CMS-1500

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.

48-Hour Rule
WellCare follows the CMS guidelines for Outpatient Services Treated as Inpatient Services (including, but 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 or the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at: portal.flmmis.com/flpublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabid/53/desktopdefault/+/_Default.aspx.

Disclosure of Coding Edits
WellCare uses claims editing software programs to assist 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 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 and/refer to Florida Statute 641.3155.

Coordination of Benefits (COB)
WellCare shall coordinate payment for Covered Services in accordance with the terms of a Member’s benefit plan, 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. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan as well as a copy of the primary payer’s Explanation of Payment (EOP). The primary carrier’s EOP should contain the name of the primary carrier, payment date, payment/denied amount, reason for denial, if applicable, billed charges and any remaining patient liability. 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.

Encounters Data

Overview
This section is intended to provide delegated vendors and Providers (IPAs) with the necessary information to allow them to submit Encounter Data to WellCare. WellCare is authorized to take whatever steps are necessary to ensure that the Provider is recognized by the Agency and its agent(s) as a participating Provider of WellCare, and the Providers submission of Encounter Data is accepted by the Agency. If Encounter Data does not meet the Service Level Agreements (SLAs) for timeliness of submission, completeness or accuracy, the Agency has 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 and Complete Encounters Submission
Unless otherwise stated in the Agreement, delegated vendors and capitated Providers should submit complete and accurate encounter files to WellCare as follows:

- For initial submission, encounters will be submitted within 60 days from service month
- For resubmission, encounters rejected by WellCare must be remediated and resubmitted 100% within seven calendar days from the date that the Provider receives the notification/response file from WellCare
- Encounters can be submitted to WellCare on a daily/weekly basis
- Providers must maintain a minimum of 95% acceptance rate for all encounters submitted within a calendar month
- All Providers must register and uniquely match against the State roster before WellCare accepts the encounters
- Encounter Compliance reports will be published to Providers on a monthly basis
- Providers who fail to comply with the Encounter SLAs are subject to be placed on a 90-day Corrective Action Plan

Fines/Penalties
The following applies if the Provider is capitated or WellCare has delegated activities to the Provider pursuant to a separate delegation addendum: Provider shall reimburse WellCare for any fines, penalties or costs of corrective actions required of WellCare by governmental
authorities caused by the Provider’s failure to comply with laws or program requirements, including failure to submit accurate encounters on a timely basis or to properly perform delegated functions.

Accurate Encounters Submission
All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 5 shall be maintained. Once WellCare receives a delegated vendor or Provider encounter, the encounter is loaded into WellCare’s Encounters System and processed. The encounter is 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 submitting encounters electronically, refer to the WellCare Companion Guides which may be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid/Claims.

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

Encounters Submission Methods
Delegated vendors and Providers may submit encounters using several methods: electronically, through WellCare’s contracted clearinghouse(s), via Direct Data Entry (DDE) 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 EDI as its preferred method of claims submission. Encounters may be submitted using WellCare’s SFTP 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/Florida/Providers/Medicaid/Claims.

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 (DDE) portal. The DDE tool can be found on the secure, online Provider Portal at www.wellcare.com/Florida/Providers. For more information on free DDE options, refer to the Florida Medicaid Provider Resource Guide on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

Encounters Data Types
There are four 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 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** – An encounter that has never been submitted to WellCare previously
- **Voided Encounter** – An encounter that WellCare deletes from the encounter file and is not submitted to the state
- **Replaced or Overlaid Encounter** – An encounter that is updated or corrected within the WellCare system

**Balance Billing**

Providers shall accept payment from WellCare for Covered Services provided to CMS Health Plan Members in accordance with the reimbursement terms outlined in 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. For more information on balance billing, refer to the Florida Statutes 641.3154 and 641.3155 (5)a.(8). Additionally, Providers shall not charge CMS Health Plan Members for missed appointments.

**Hold Harmless Dual-Eligible Members**

Those dual-eligible Members whose Medicare Part A and B Member Expenses are identified and paid for at the amounts provided for by Florida Medicaid shall not be billed for such Medicare Part A and B Member Expenses, regardless of whether the amount a Provider receives is less than the allowed Medicare amount or Provider charges are reduced due to limitations on additional reimbursement provided by Florida Medicaid. Providers shall accept WellCare’s payment as payment in full or will bill Florida Medicaid if WellCare has not assumed the Agency’s financial responsibility under an agreement between WellCare and the Agency.

**Claims Appeals**

The claims Appeal 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 one year of the date of denial of the Explanation of Payment (EOP).

Documentation consists of:
- (a) Date(s) of service;
- (b) Member name;
- (c) Member CMS Health Plan Member ID number and/or date of birth;
- (d) Provider name;
- (e) Provider Tax ID/TIN;
- (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 refer to the Quick Reference Guide on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid).

**Operations Account Resolution (OAR) Process**

If a Provider has exhausted its rights of appeal, it may request further review by CMS Health Plan pursuant to its Operations Account Resolution (OAR) Process, which is an informal complaint review process offered by The Plan. The process includes the following:

- Dedicated OAR representatives for Providers to contact via electronic mail at PSU_ProviderInquiries@wellcare.com, or by calling: **1-877-378-2488** Monday-Friday
from 8 a.m. to 4:30 p.m. Eastern Time to get clarification and education on claims issues as well as additional review of denied claims

- Providers are encouraged to use the regular Customer Service number and the dedicated number for the Provider Resolutions Team (PRT) prior to contacting OAR, and will be asked to provide a reference number from customer service or PRT to review what actions were previously taken on the claims issue

- Dedicated personnel to receive and process Provider requests for additional claims review. The OAR team will work closely with Customer Service and Provider Resolution staff to quickly address issues

- Providers are permitted 45 calendar days to file a written request for review of claims–related issues

- The Plan will notify the Provider (verbally or in writing) within three business days of receipt of a request to review a denied claim, that the request has been received and the expected date review will be completed

- Once a request is received, CMS Health Plan will thoroughly investigate each request, collect the necessary information and apply applicable statutory, regulatory, contractual and Provider agreement provisions.

- If a request for review is not completed within 15 calendar days of the Plan’s receipt of the request, the Plan will provide written notice of the status to the Provider, and every 15 calendar days thereafter until the review has been completed

- The Plan will attempt to complete its review of all request within 60 calendar days of receipt and will provide written notice of its decision and the basis for it to the Provider within three business days of the review being completed.

- Non-claims issues will be routed to the Grievance department. Please see Section 7: Appeals and Grievances for more information.

MAXIMUS Claim Dispute Resolution Program
If a Provider’s issue is not resolved to their satisfaction and OAR has determined that CMS Health Plan processed the claim or handled the concern correctly, the Provider may have the opportunity to utilize Maximus, an independent dispute resolution organization as an appeal process, if both the Provider and The Plan agree to use the process. CMS Health Plan reserves the right not to use Maximus at its sole discretion and may decline to use Maximus at any time, including if a claim meets the criteria for review by Maximus as indicated below.

General Information
To qualify, claim disputes must have been denied in full or in part, or were presumed to have been underpaid or overpaid.

Application forms and instructions on how to file claims are available from MAXIMUS directly at 1-866-763-6395 (select 1 for English or 2 for Spanish), and then select Option 2. Ask for Florida Provider Appeals Process.

Eligible Claims
The following claim disputes can be submitted by physicians, hospitals, institutions, other licensed healthcare providers, HMOs, Prepaid Health Clinics, Prepaid Health Plans, and Exclusive Provider Organizations (EPOs).

- Claim disputes for services rendered after Oct. 1, 2000 (the effective date of the
• Claim disputes related to payment amounts only – provider disputes payment amount received, or HMO disputes payback amount. **Claim disputes related exclusively to late payment are not eligible.**

• Hospitals and Physicians are required to aggregate claims **(for one or more patients for same insurer)** by type of service to meet certain minimum thresholds:
  
  o Hospital Inpatient Claims (contracted providers) $25,000  
  o Hospital Inpatient Claims (noncontracted providers) $10,000  
  o Hospital Outpatient Claims (contracted providers) $10,000  
  o Hospital Outpatient Claims (noncontracted providers) $3,000  
  o Physicians/Dentists $500  
  o Rural Hospitals none  
  o Other Providers none

**Ineligible Claims**

• Claims for less than minimum amounts listed above for each type of service  
• Claim disputes that are the basis for an action pending in State/Federal court  
• Claim disputes that are subject to an internal binding managed care organization’s resolution process for contracts entered into prior to Oct. 1, 2000  
• Claims solely related to late payment and/or late processing  
• Interest payment disputes  
• Medicare claim disputes that are part of Medicare Managed care internal grievance or that qualify for Medicare reconsideration appeal  
• Claims related to health plans not regulated by the state of Florida  
• Claims filed more than 12 months after final determination by health plan or provider

**MAXIMUS Review Process/Time Frames**

MAXIMUS has 60 days to resolve claim disputes and make recommendations to the Agency after receipt of the appropriate forms and documentation. The filing party has to submit a copy of the documentation to the adversely affected party at the same time. MAXIMUS has the right to request additional documentation from both parties. The total review time shall not exceed 90 days following receipt of the initial claim dispute.

The Agency has 30 days to issue a final order based on the recommendation made by MAXIMUS.

**Review Cost**

The Legislature did not provide any funding for this program with the exception of funding for one Agency attorney.

Pursuant to Florida Statutes the full review costs have to be paid by the non-prevailing party. If both parties prevail in part, the review cost will be apportioned based on the disputed claim amount. If the non-prevailing party or parties fail(s) to pay the ordered review costs within 35 days after the Agency's final order, the non-paying party or parties are subject to a fine of $500 per day. Entities filing a claim that is settled prior to any decision rendered by MAXIMUS have to pay the full review costs.
The Agency has no fine authority to enforce payment of the disputed claim amount. However, the Agency has authority to enforce its final order based on section 641.52(1) (e), Florida Statutes.

Fee Schedule
Since each claim dispute is different and of varying complexity, the contractor will not be able to estimate the full cost in advance, MAXIMUS has agreed by contract to the following fee schedule:

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Expert Review</td>
<td>$215/hr</td>
</tr>
<tr>
<td>Utilization Review Nurse</td>
<td>$95/hr</td>
</tr>
<tr>
<td>Medical Claim Coding Expert</td>
<td>$125/hr</td>
</tr>
<tr>
<td>Legal Expert</td>
<td>$175/hr</td>
</tr>
<tr>
<td>Initial Review Fee to Determine Eligibility</td>
<td>$75 flat fee</td>
</tr>
</tbody>
</table>

MAXIMUS will provide a review cost estimate in advance, if requested, at no additional charge beyond the initial review fee. However, review costs based on the final order from AHCA must be paid directly to MAXIMUS.

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

How to submit a Corrected or Voided Claim electronically:
- Loop 2300 Segment CLM composite element CLM05-3 should be “7” or “8” – indicating to replace “7” or void “8”
- Loop 2300 Segment REF element REF01 should be “F8” indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be ‘the original claim number’ – the control number assigned to the original bill (original claim reference number for the claim to be replaced.)
- Example: REF＊F8＊Wellcare Claim number here～

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, the 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”

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

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 OR 8</td>
<td>123456789012A33456</td>
</tr>
</tbody>
</table>

Any missing, incomplete or invalid information in any field may cause the claim to be rejected. **Please Note:** If the Provider handwrites, stamps, or types “Corrected Claim” on the claim form without entering the appropriate Frequency Code (7 or 8) along with the Original Reference Number as indicated above, the claim will be considered a first-time claim submission.

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 EOP than the EOP that is sent for the newly submitted corrected claim.

**Reimbursement**
WellCare applies the CMS Site-of-Service payment differentials in its fee schedules for Current Procedural Terminology (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:

- 100% of maximum allowable fee for primary surgical procedure
- 50% of maximum allowable fee for secondary surgical procedure
- 25% of maximum allowable fee for all other surgical procedures

The percentages apply when eligible multiple surgical procedures are performed under one continual medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

**Assistant Surgeon**

Assistant Surgeons (AS) are reimbursed 16% of the maximum allowable fee for the procedure code. Multiple surgical procedures for AS are reimbursed as follows:

- 16% of 100% of the maximum allowable fee for primary surgical procedure (first claim line)
- 16% of 50% of the maximum allowable fee for the second surgical procedure
- 16% of 25% of the maximum allowable fee for all other surgical procedures

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**

Each Provider will be paid 60% of the maximum allowable fee for the procedure code. 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**

Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code’s fee or cause a claim to pend for review. The pricing modifiers are 22, 24, 25, 26, 50, 51, 52, 54, 55, 56, 59, 62, 66, 76, 77, 78, 79, 80, and 99, LT/RT, QK, QS, and TC.

**Allied Health Providers**

If there are no reimbursement guidelines on the Florida Medicaid website specific to payment for non-physician practitioners or Allied Health Professionals, WellCare follows CMS reimbursement guidelines regarding Allied Health Professionals.

For more information on reimbursement payments, refer to the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at portal.flmmis.com/fipublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabid/53/desktopdefault/+Default.aspx.
**Telemedicine**
Telemedicine is a covered plan benefit subject to limitations and administrative guidelines. Telemedicine is defined as the practice of healthcare delivery by a practitioner who is located at a site other than the site where a Member is located for the purpose of evaluation, diagnosis, or treatment. Telemedicine services provide the Member with enhanced healthcare services, the opportunity to improve health outcomes, and information when meeting face-to-face is unavailable. CMS Health Plan agrees to provide coverage for services provided through telemedicine, when appropriate, for services covered under this Contract, to the same extent the services would be covered if provided through a face-to-face (in-person) encounter with a practitioner. CMS Health Plan also covers store-and-forward and remote patient monitoring services, when appropriate, as a part of its Quality Enhancement programs.

Under the CMS Health Plan, WellCare reimburses for:
- Practitioners providing telemedicine services licensed within their scope of practice to perform the service.
- Telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.
- Provider must include modifier GT on the CMS-1500 claim form to indicate the delivery method was telemedicine or GQ modifier to indicate store and forward.
- To indicate that the billed service was furnished as telemedicine from a distant site submit claims for telemedicine services using Place of Service (POS) 02: Telehealth.

Under the CMS Health Plan, WellCare does not reimburse for:
- Standard phone calls, chart review(s), faxes or email – in combination or individually – as these are not considered Telemedicine Services.
- Issuing a prescription based solely on an online questionnaire does not constitute a telemedicine service and is not covered.
- Equipment required to provide telemedicine services.

**Administrative Guidelines:**
A. Services that require precertification when rendered in-person also require precertification when rendered via telemedicine. Providers are required to follow WellCare’s coverage criteria.
B. Documentation supporting medical necessity should be legible and maintained in the patient’s medical record and made available to WellCare upon request. The medical chart organization and documentation shall, at a minimum, include a brief explanation of the health services delivered through telemedicine in each progress note and documentation of telemedicine equipment used for the particular services provided. WellCare reserves the right to perform retrospective reviews using the above criteria to validate if services rendered met Payment Determination Criteria.
C. Providers must ensure that a member agrees to the use of telemedicine and obtain an informed consent form. Providers are required to retain a copy of the informed consent form in the member’s medical record.
D. All telemedicine services provided must be consistent with all federal and state privacy, security, and confidentiality laws, and all state and federal laws governing telemedicine services.
E. Any health professional providing health services via telemedicine must be currently and appropriately licensed in the State of Florida and must be contracted and credentialed through WellCare’s network.

F. All telemedicine services provided must be consistent with WellCare’s terms and conditions.

G. WellCare obligates all telemedicine providers to have protocols to prevent fraud and abuse, including:
   • Authentication and authorization of users
   • Authentication of the origin of the information
   • The prevention of unauthorized access to the system or information
   • System security, including the integrity of information that is collected, program integrity and system integrity
   • Maintenance of documentation about system and information usage

Overpayment Recovery
WellCare strives for 100% payment quality, but recognizes that a small percentage 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, non-covered benefit(s) and other reasons.

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will limit its recovery effort to 12 months from the payment date for professional claims (CMS-1500 or its successor) and 30 months from the payment date for institutional claims (UB-04 or its successor), with the exception for retrospective disenrollment, where institutional claims are also limited to 12 months from the payment date. These time frames do not apply to fraudulent or abusive billing and there is no deadline for WellCare to seek recovery from the Provider. In all cases, WellCare or its designee will provide a written notice to the Provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Member. The notice will also provide the carrier address WellCare has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 45 days for the Provider to send in the refund, request further information, appeal or dispute the retroactive denial.

Failure of the Provider to respond within the above time frame will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an EOP indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months and no refund has been received, the Provider may be contacted by WellCare, or its designee, to arrange payment.

If a Provider independently identifies an overpayment, WellCare requires the Provider to 1) report that an overpayment has been received; 2) return the overpayment within 60 calendar days of the date the overpayment was identified; and 3) notify WellCare in writing as to the reason for the overpayment to:

WellCare Health Plans, Inc.
P.O. Box 31584
Tampa, FL 33631-3584
Providers with any questions about this can call Provider Services toll-free at 1-866-799-5321. Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m. Eastern Time.

For more information on contacting Provider Services, refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/en/Florida/Providers/Medicaid.

Benefits During Disaster and Catastrophic Events
Refer to Provider Agreement.
Section 6: Credentialing

Overview
Credentialing is the process by which the appropriate WellCare peer review bodies 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/healthcare 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/healthcare 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 that may affect a practitioner’s ability to provide healthcare
- 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 CMS Health Plan Members. CMS Health Plan will only register a participating Provider with DOH and AHCA after a background screening has been completed.

The CMS Health Plan will verify that a Level 2 background check was performed to validate the eligibility of the CMS Health Plan treating Providers not currently enrolled in the fee-for-service program.

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/healthcare delivery organizations are required to be credentialed in order to be network Providers of services to CMS Health Plan Members.

Satisfactory site inspection evaluations are required to be performed in accordance with state, federal, 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. The delegated entity’s contract must first be approved by AHCA prior to implementation.

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 emailed to credentialinginquiries@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 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 Time Frame
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
- 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. PCPs for CMS Health Plan must be Board certified in either Family Practice or Pediatrics.

**Special Provisions for CMS Health Plan Providers** – Primary Care Providers who have recently completed a National Board for Certification of Training Administrators of Graduate Medical Education Programs-approved residency program in pediatrics or family practice and are eligible for board certification but have not yet achieved board certification may participate as Providers in the CMS Health Plan. If the non-board-certified Primary Care Provider does not achieve board certification within the first three years of initial credentialing, the Provider will be removed from the Plan panel and Members will be reassigned.

**Hospital-Admitting Privileges** – Specialist practitioners shall have hospital-admitting privileges at a WellCare-participating hospital (as applicable to specialty). PCPs 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. Providers are not eligible for participation if such Provider owes money to the Medicaid Program or if the Office of the Attorney General has an active fraud investigation involving the Provider. 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.

**New Providers** – A Provider is required to have a Florida Medicaid Provider number as well as a National Provider Identifier (NPI) to participate in WellCare’s network. **CMS Health Plan Providers are not required to have a Florida Medicaid Provider number.**

**Providers who 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 website to determine whether a Provider has opted out of Medicare. Ongoing/quarterly monitoring of the opt-out website is performed by WellCare.

**Liability Insurance**
WellCare requires individual Providers to meet professional liability insurance in accordance with Florida Statute Chapter 438 §32:
- $250,000 per occurrence, $750,000 aggregate, if Provider has hospital privileges
- $100,000 per occurrence, $300,000 aggregate, if individual has no hospital privileges
- Physicians practicing in County Public Health Departments or Federally Qualified Health Centers may submit evidence of coverage under Sovereign Immunity
- Active practicing Providers may opt to carry no medical malpractice insurance if they meet the following criteria:
  1. The Provider has held an active license in any state for more than 15 years
  2. The Provider has either retired from the practice of medicine or maintains a part-time practice of no more than 1,000 patient contact hours per year
  3. The Provider has had no more than two medical malpractice decisions resulting in an indemnity exceeding $25,000 within the previous five-year period
  4. The Provider has not been convicted of, or pleaded guilty or nolo contendere to, any criminal violation specified in Florida Statute Chapter 438
  5. The Provider has not been subject within the last 10 years of practice to license revocation or suspension for any period of time; probation for a period of three years or longer; or a fine of $500 or more for a violation of this chapter or the medical practice act of another jurisdiction
  6. The Provider must post notice in the form of a sign prominently displayed in the reception area and clearly noticeable to all patients or provide a written statement to any person to whom medical services are being supplied that he/she has decided not to carry medical malpractice insurance, pursuant to Florida law

Atypical facilities and Providers contracted are required to be licensed, bonded and insured according to minimum industry standards of the field in which they are operating.

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

**Site Inspection Evaluation (SIE)**
Site Inspection Evaluations (SIEs) 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 accessibility
- Physical appearance
- Adequacy of waiting room and examination room space
- Medical/treatment record keeping criteria

SIEs are conducted for:
- Unaccredited facilities
- State-specific initial credentialing requirements
- State-specific re-credentialing requirements
- When complaint is received relative to office site criteria

SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs 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.

Attestation to Active Patient Load
An attestation that the total active patient load (all populations with Medicaid FFS, Children’s Medical Services Network, HMO, PSN, Medicare and commercial coverage) is no more than 3,000 patients per PCP is required. An active patient is one that is seen by the Provider a minimum of three times per year.

Allied Health Professionals
Allied Health Professionals (AHPs), both dependent and independent, are credentialed by WellCare.

Dependent AHPs include the following, and are required to provide collaborative practice information to WellCare:
- Advanced registered nurse practitioners (ARNPs)
- Certified nurse midwives (CNMs)
- Physician assistants (PAs)
- Osteopathic assistant (OAs)

Independent AHPs include, but are not limited to, the following:
- Licensed clinical social workers
- Licensed behavioral health counselors
- Licensed marriage and family therapists
- Physical therapists
- Occupational therapists
- Audiologists
- Speech/language therapists/pathologists

Ancillary Healthcare Delivery Organizations
Ancillary and organizational applicants must complete an application and, as applicable, undergo an 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 years. For process and requirements please see Section 6: Credentialing

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 monthly 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.

Eligibility in the Medicaid Program
All Providers must be eligible for participation in the Medicaid program. If a Provider is currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that Provider is not considered an eligible Medicaid Provider. Suspension and termination are described further in Rule 59G-9.070, F.A.C. If a Provider is found to be ineligible for participation in the Medicaid program, the Provider is subject to immediate termination from WellCare.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials
On a monthly 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 as a first-level Peer Review Panel consisting of at least three qualified individuals of whom at least one 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 qualified individuals, of whom at least one is a participating Provider and a clinical peer of the practitioner that filed the dispute. 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
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service
- 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 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 or 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 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 10 calendar days of the request for a second-level Peer Review Panel hearing, the Medical Director or his or 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 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 or she 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 *Section 9: Delegated Entities* section in this Manual for further details.
Section 7: Appeals and Grievances

Appeals Process

Provider

Provider on Behalf of Self Appeals Process
A Provider may request an appeal regarding Provider payment or contractual issues on his or her own behalf by mailing a letter of appeal and/or an appeal form with supporting documentation, such as medical records to WellCare.

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 time frame, the Provider may submit documentation showing proof of timely filing. 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 will notify providers verbally or in writing regarding the receipt of the request for an appeal within three business days.

WellCare has 60 calendar days to review the case for Medical Necessity and/or 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 reopen 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 Provider on Behalf of Self Appeals
If all of the relevant information is received, WellCare will make a determination within 60 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.

Affirmation of Denial of Provider on Behalf of Self Appeals
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 may be provided. 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 address 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 request verbally with Customer Service at the phone number below or on the back of the Member’s ID card. An appeal may also be submitted in writing. All requests must be submitted within 60 calendar days from the date on the Notice of Adverse Benefit Determinations (NABD). CMS Health Plan will acknowledge in writing within five business days of receipt of appeal except in the case of an expedited request.

There is only one level for an internal appeal. For medical appeals, the Member should send the appeal request to:

**CMS Health Plan**
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

Fax: 1-866-201-0657
CMS Health Plan Telephone: 1-866-799-5321
CMS Health Plan Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m. Eastern Time

For pharmacy appeals, the Member should send the appeal request to:

**CMS Health Plan**
Attn: Pharmacy Medication Appeals Department
P.O. Box 31398
Tampa, FL 33631-3398

Fax: 1-888-865-6531
CMS Health Plan Telephone: 1-866-799-5321
CMS Health Plan Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m. Eastern Time

If an appeal is filed verbally via CMS Health Plan Customer Service, the request must be followed up with a written, signed appeal request to CMS Health Plan within 10 calendar days of the verbal filing, except when an expedited resolution has been requested. For verbal filings, the time frames for resolution begin on the date the verbal filing was received by WellCare once written confirmation is received.

If the Member’s request for appeal is submitted after 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD), 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 following:
- The Member did not personally receive the notice of adverse benefit determination or received the notice 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
• The Member had incorrect or incomplete information concerning the Appeal process

If the Member wishes to use a representative, he or she must submit a signed statement naming the person he or she wishes to represent him or her. This appointment is also required for the Member’s PCP or Provider to assist with the Member’s request for appeal. For the Member’s convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The Member and the person who will be representing the Member must sign the AOR statement. The form is on WellCare’s website at www.wellcare.com/en/Florida/Providers/Medicaid/Forms.

Members are provided 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 capability.

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. See CMS Health Plan Provider on Behalf of Self Appeals Process above for more information.

There is only one level of appeal with the Plan. The Member, Member’s representative or a Provider acting on the Member’s behalf with the Member’s consent may file for an expedited, standard pre-service or retrospective appeal determination.

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, the following:
• Denial or limited authorization of a requested service, including the type or level of service pursuant to 42 CFR 438 400(b)
• The reduction, suspension or termination of a previously authorized service
• The denial, in whole or in part, of a payment for service
• The failure to provide services in a timely manner, as defined by the Agency
• The failure of WellCare to act within 60 calendar days or maximum of 90 calendar days if the grievance involves the collection of information outside of the service area; or 30 calendar days from the date WellCare receives an appeal
• For a resident of a rural area with only one managed care entity, the denial of a Member’s request to exercise his or her right to obtain services outside the network

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 healthcare 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.
Upon the receipt for a request for an appeal, the Plan will acknowledge the appeal in writing within five business days from the receipt of the appeal unless the member request an expedited resolution.

WellCare shall notify Members in their primary language of appeal resolutions. 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: **48 hours**
- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **30 calendar days**

The Standard Pre-Service and Retrospective Determination periods noted above may be extended by up to 14 calendar days if the Member requests an extension or if CMS Health Plan justifies a need for additional information and documents how the extension is in the interest of the Member. If an extension is not requested by the Member, CMS Health Plan will notify the Member verbally of the extension and provide the Member with written notice of the reason for the delay within two calendar days of the decision to extend the time frame.

**Expedited Appeals Process**
To request an expedited appeal, a Member or a Provider (regardless of whether the Provider is contracted with WellCare) must submit a verbal or written request directly to WellCare. A request to expedite an appeal 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.

Members who verbally request an expedited appeal are not required to submit a written appeal request as outlined in the Appeals Member section.

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

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. The timeframe to submit additional information for an expedited appeal is limited due to the short timeframe to process the file. Members may also review a copy of their case file any time during and or after the completion of the appeal review.

**Denial of an Expedited Request**
WellCare will provide the Member with prompt verbal notification by the end of business the day of the decision being made regarding the denial of an expedited appeal and the Member’s rights, and will subsequently mail to the Member within two calendar days of the verbal notification, a written letter that explains:

- That WellCare will automatically transfer and process the request using the 30 calendar day time frame for standard Appeals beginning on the date WellCare received the original request and
- The Member’s right to file an expedited grievance if she or he disagrees with the organization’s decision not to expedite the appeal and provide instructions about the expedited grievance process and its time frames
Resolution of an Expedited Appeal
Upon an expedited appeal of an adverse determination, WellCare will complete the expedited appeal 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 48 hours after receiving a valid complete request for appeal.

Reversal of Denial of an Expedited Appeal
If WellCare overturns its initial action and/or the denial, it will issue an authorization to cover the requested service and notify the Member verbally by end of business the day the decision is made, followed by 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:
• Verbally notify the Member of the decision by end of business the day the decision is made
• Issue a Notice of Notice of Plan Appeal Resolution to the Member and/or appellant
• Include in the Notice the specific reason for the Appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
• Inform the Member:
  o For Title XIX members only: Of their right to request a Medicaid Fair Hearing within 120 calendar days of receipt of the notice of plan appeal resolution and how to do so.
  o Of their right to representation
  o Of their right to continue to receive benefits pending a Medicaid Fair Hearing
  o That they may be liable for the cost of any continued benefits if WellCare’s action is upheld
  o For Title XXI members only: Of their right to request an Independent External Review within four months (120 calendar days) of receipt of the notice of Plan Appeal Resolution and how to do so.

Standard Appeals (Pre-Service and Retrospective) Process
A Member, a Member’s representative or a Provider on behalf of a Member with the Member’s written consent, may file a standard appeal request either verbally or in writing within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD).

If an appeal is filed verbally through Customer Service, the request must be followed up with a written, signed appeal to WellCare within 10 calendar days of the verbal filing. For verbal filings, the time frames for resolution begin on the date the verbal filing was received with written confirmation of the request for appeal.

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. Members may also review a copy of their case file any time during and or after the completion of the appeal review free of charge.

Reversal of Denial of a Standard Appeal
If upon standard appeal, WellCare overturns its adverse organization determination denying a Member’s request for a service, then WellCare will issue an authorization or payment for the request.
WellCare will issue an authorization for the disputed services if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services. WellCare will also pay for the disputed services if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

**Affirmation of Denial of a Standard Appeal**
If WellCare affirms its initial action and/or denial (in whole or in part), it will:
- Issue a Notice of Adverse Benefit Determination (NABD) to the Member and/or appellant
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the Member:
  - **For Title XIX members only**: Of their right to request a Medicaid Fair Hearing within 120 calendar days of receipt of the notice of plan appeal resolution and how to do so.
  - Of their right to representation
  - Of their right to continue to receive benefits pending a Medicaid Fair Hearing
  - That they may be liable for the cost of any continued benefits if WellCare’s action is upheld
  - **For Title XXI members only**: of their right to request an Independent External Review within four months (120 calendar days) of receipt of the notice of Plan Appeal Resolution and how to do so.

**Medicaid Fair Hearing – For Title XIX members only**
For Title XIX members only, if the Member is not satisfied with WellCare’s appeal decision, the Member can ask for a Medicaid Fair Hearing.

Members may ask for a Fair Hearing any time up to 120 calendar days after they get the Notice of Plan Appeal Resolution letter. Members may ask for a Medicaid Fair Hearing only after they complete WellCare’s internal appeal process.

They may ask for a Medicaid fair hearing by calling or writing to:

**Agency for Health Care Administration**
**Medicaid Hearing Unit**
P.O. Box 60127
Fort Myers, FL 33906

Telephone: 1-877-254-1055 (toll-free)
Fax: 1-239-338-2642
**MedicaidHearingUnit@ahca.myflorida.com**

A Member’s written request for a Medicaid Fair Hearing or State Review must include the following information:
- Name
- Member number
- Medicaid ID number (Not applicable to MediKids)
- Phone number where WellCare can reach Member or Member’s authorized representative
Members are encouraged to include the following information if they have it:
- Why they think WellCare should change the decision
- Any medical information to support the request
- Whom they would like to help them with the fair hearing

After getting a Member’s Fair Hearing or State Review request, the Office of Fair Hearing will tell the Member in writing that the request was received.

**Independent External Review – For Title XXI members only:**
For Title XXI members only, if the Member is not satisfied with WellCare’s appeal decision, the Member can ask for an independent External Review with the Plan.

How to Ask for an External Review:
You may ask for an external review 120 days after you get this Notice of Plan Appeal Resolution.

You may ask for an external review by calling, writing, or faxing a request to the Plan.

For Medical Appeals, please send your request to:
CMS Health Plan
Attn: Appeals Coordinator
P.O. Box 31368
Tampa, FL 33631-3368
Fax: 1-866-201-0657

For Pharmacy Appeals, please send your request to:
CMS Health Plan
Attn: Pharmacy Appeals
P.O. Box 31398
Tampa, FL 33631-3398
Fax: 1-888-865-6531

Your written request for an External Review must include the following information:
- Your name
- Your member number
- And reason why you want an external review

You may also include the following information if you have it:
- Why you think we should change the decision
- Any medical information to support the request

After getting your external review request, the Plan will forward your information to an Independent External Reviewer for a decision.

**Continuation of Benefits while the Appeal and Medicaid Fair Hearing is Pending – For Title XIX members only.**

For Title XIX members, Members may ask that WellCare continue to cover their medical services during the appeals process. To do this:

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WellCare Health Plans, Inc.
Children’s Medical Services Health Plan Provider Manual
Effective April 22, 2019
Provider Services (toll free): 1-866-799-5321
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- Members must file their appeals with WellCare within 10 calendar days of WellCare mailing the Notice of Adverse Benefit Determinations (NABD) to them or within 10 days after the date the service will be reduced, suspended or stopped, whichever is later.
- The Member’s appeal involves an action WellCare is taking to reduce, suspend or stop a service it already had approved.
- The service must have been ordered by an authorized Provider.
- The original time period covered by the approval WellCare gave has not yet ended
- Members must ask for a continuation of benefits timely.

WellCare will continue a Member’s benefits until one of the following happens:

1. The Member withdraws the appeal.
2. 10 days pass after WellCare sends the Member the notice of adverse benefit determination letter.
3. The Fair Hearing officer issues a hearing decision adverse to the member.

If the final resolution of the appeal or hearing is adverse to the Member (i.e., WellCare’s decision was upheld), WellCare may recover from the Member the cost of the services furnished to the Member while the appeal was pending, to the extent that they were furnished solely because of the requirements of the contract.

If the final resolution of the appeal or hearing is reversed by the hearing decision and services were not furnished while the plan appeal was pending, The Plan will authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date the Plan received the notice reversing the determination.

**Grievance Process**

**Provider Complaints**

Providers have the right to file a written complaint for issues that are non-claims related no later than 45 calendar days from the date the Provider becomes aware of the issue generating the complaint. Written resolution will be provided by WellCare to the Provider within 90 calendar days from the date the complaint is received by WellCare. Providers with complaints unresolved during Provider Service Resolution (PSR) process, or if the Provider makes his/her request known, may request to file a Provider complaint.

A verbal acknowledgment will be made to the Provider filing the complaint within three business days, acknowledging receipt of the complaint and the expected date of resolution.

All complaints shall be resolved within 90 calendar days of receipt and provide a written notice of the disposition and the basis of the resolution to the Provider within three business days of resolution. If the complaint is unresolved after 15 calendar days of receiving the complaint, documentation explaining why and a written notice of the status to the Provider every 15 calendar days thereafter.

A written notice of the disposition and basis of the resolution will be mailed to the Provider within:
• Three business days of the resolution

A written Provider complaint shall be mailed directly to WellCare’s Grievance Department.

For more information on the Grievance Department, refer to the Quick Reference Guide, which may be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

When acting as the Member’s representative, a Provider may not file a grievance on behalf of the Member without written consent from the Member.

WellCare will give all Providers written notice of the Provider grievance procedures at the time they enter into contract.

For more information, see the Grievance Submission section.

**Member**

The CMS Health Plan 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
  - Failure to respect the Member’s rights
  - Quality of care/services provided
  - Refusal to see Member (other than in the case of patient discharge from office)
  - Office conditions

- **Services provided by CMS Health Plan including, but not limited to:**
  - Hold time on telephone
  - Rudeness of staff
  - Involuntary disenrollment from WellCare
  - Unfulfilled requests

- **Access availability including, but not limited to:**
  - Difficulty getting an appointment
  - Wait time in excess of one hour
  - Handicap accessibility

A CMS Member, a CMS Member’s representative or any Provider acting on behalf of the Member with written consent, may file a grievance at any time.

WellCare will ensure that no punitive action is taken against a Provider who, as an authorized representative, files a grievance on behalf of a Member, or supports a grievance filed by a Member. Documentation regarding the grievance will be made available to the Member, if requested.

If the Member wishes to use a representative, then he or she must submit a signed statement naming the person he or she wishes to represent him or her. For the Member’s convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The Member and the person who will be representing the Member must sign the AOR statement. The form is on WellCare’s website at www.wellcare.com/en/Florida/Providers/Medicaid/Forms.
Members are provided reasonable assistance in completing forms and other procedural steps for a Grievance, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability.

**Grievance Submission**

A verbal grievance request can be filed, toll-free, with CMS Health Plan Customer Service. A verbal request may be followed up with a written request by the CMS Health Plan Member, but the time frame for resolution begins the date the verbal filing is received by WellCare.

The CMS Health Plan Member should send the grievance request to:

**CMS Health Plan Grievances**  
P.O. Box 31384  
Tampa, FL 33631-3384  

Fax: 1-866-388-1769  
Telephone: 1-866-799-5321  
Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m.

**Grievance Resolution**

CMS Health Plan will acknowledge the CMS Health Plan Member grievances in writing within five business days from the date the grievance is received by us. Upon the grievance resolution, a letter will be mailed to the CMS Health Plan Member: (a) within 60 calendar days, but no more than 90 calendar days from the date the grievance is received by us. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent, then one letter shall be sent which includes the acknowledgement and the decision of the grievance.

A CMS Health Plan Member has the right to request a 14-calendar day extension, if the Member has additional information to support the Member’s grievance. CMS Health Plan has the right to request to extend the Member’s resolution, if it is in the Member’s best interest. If CMS Health Plan extends the grievance, we will provide the Member oral notification with a reason for the delay, by close of business on the day the decision is made; and in writing within two calendar days of the decision.

The acknowledgement letter includes:
- Name and telephone number of the Grievance Coordinator
- Request for any additional information, if needed to investigate the issue

The resolution letter includes:
- The results/findings of the resolution
- All information considered in the investigation of the grievance
- The date of the grievance resolution

CMS Health Plan will notify Members of grievance resolutions in their primary language.
Section 8: Compliance

WellCare’s Compliance Program

Overview
WellCare maintains a Corporate Compliance Program (Compliance Program) that promotes ethical conduct in all aspects of the company’s operations, and ensures compliance with WellCare policies and applicable federal and state regulations. The Compliance Program 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 subcontractors and their employees, are required to comply with WellCare Compliance Program requirements. WellCare’s compliance-related training requirements include, but are not limited to:

- Compliance Program Training
  - To ensure policies, procedures and related compliance concerns are clearly understood and followed
  - To provide a mechanism to report suspected violations and implement disciplinary actions to address violations

- HIPAA Privacy and Security Training
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act
  - Training includes, but is not limited to, discussion on:
    - Proper Uses and Disclosures of Protected Health Information (PHI)
    - Member Rights
    - 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 subcontractors 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
  - Programs to educate and identify the diverse cultural and linguistic needs of the Members that Providers 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
Providers, including Provider employees and/or Provider subcontractors, 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 subcontractors, or by WellCare Members. Reports may be made anonymously through the WellCare fraud hotline at 1-866-678-8355.

Details of the corporate ethics and compliance program may be found on our website at www.wellcare.com/Florida/Corporate/About-Us.

**Provider Education and Outreach**

Providers may:
- Display state-approved CMS Health Plan-specific materials in-office
- Announce a new affiliation with a health plan
- Make available and/or distribute DOH-approved marketing materials as long as the Provider and/or the facility distributes, or makes available, marketing materials for all Managed Care Plans with which the Provider participates
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers and print advertisement

Providers are prohibited from:
- Verbally, or in writing, comparing benefits or Providers networks among health plans, other than to confirm their participation in a health plan’s network
- Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity
- Furnishing health plans’ membership lists to the health plan, such as WellCare, or any other entity
- Assisting with health plan enrollment or disenrollment

**Provider-Based Marketing Activities**

Providers may:
- Make available and/or distribute DOH-approved marketing materials as long as the Provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the Provider participates. If a Provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates
- Display posters or other materials in common areas such as the Provider’s waiting room

Providers must comply with the following:
- To the extent that a Provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the Provider may do so
- May engage in discussions with recipients should a recipient seek advice. However, Providers must remain neutral when assisting with enrollment decisions

Providers may also:
- Provide the names of the Managed Care Plans with which they participate
- Make available and/or distribute Managed Care Plan marketing materials
• Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office
• Share information with patients from the Agency’s website or DOH’s website

Providers are prohibited from:
• Offering marketing/appointment forms
• Making phone calls to direct, urge or attempt to persuade recipients to enroll in the Managed Care Plan based on financial or any other interests of the Provider
• Mailing marketing materials on behalf of the Managed Care Plan
• Offering anything of value to induce recipients/Members to select them as their Provider
• Offering inducements to persuade recipients to enroll in the Managed Care Plan
• Conducting health screening as a marketing activity
• Accepting compensation directly or indirectly from the Managed Care Plan for marketing activities
• Distributing marketing materials within an exam room setting
• Furnishing to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan

Provider Affiliation Information:
• Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites)
• Providers may make new affiliation announcements within the first 30 calendar days of the new Provider Agreement
• Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone
• Additional direct mail and/or email communications from Providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the Provider contracts
• Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency
• Multiple Managed Care Plans can either have one Managed Care Plan submit the material on behalf of all the other Managed Care Plans, or have the piece submitted and approved by the Agency prior to use for each Managed Care Plan. Materials that indicate the Provider has an affiliation with certain Managed Care Plans and that only list Managed Care Plan names and/or contact information do not require Agency approval
• Providers may distribute state-approved printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the Providers contract. The Managed Care Plan shall ensure that:
  (i) Materials do not “rank order” or highlight specific Managed Care Plans and include only objective information
  (ii) Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution
  (iii) The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials
All subcontractors and Providers providing marketing and/or information materials (printed, web-based etc.) that are Member-facing require DOH prior to use. In such cases, the materials should be submitted to WellCare who will file the materials with DOH for approval, on behalf of the subcontractor or Provider.

**Code of Conduct and Business Ethics**

**Overview**
WellCare has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. WellCare’s Code of Conduct and Business Ethics policy can be found at [www.wellcare.com/Florida/Corporate/Compliance](http://www.wellcare.com/Florida/Corporate/Compliance).

The Code of Conduct and Business Ethics (the Code) is the foundation of iCare, WellCare’s Corporate Ethics and Compliance Program. It describes WellCare’s firm commitment to operate in accordance with the laws and regulations governing its business and accepted standards of business integrity. All Providers should familiarize themselves with WellCare’s Code of Conduct and Business Ethics. Participating Providers and other contractors of WellCare are encouraged to report compliance concerns and any suspected or actual misconduct. Report suspected Fraud, Waste and Abuse by calling the WellCare FWA Hotline at **1-866-678-8355**.

**Fraud, Waste and Abuse**
WellCare is committed to the prevention, detection and reporting of healthcare fraud and abuse according to applicable federal and state statutory, regulatory and contractural 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 healthcare service use, including overutilization, unbundling, upcoding, misuse of modifiers and other common schemes.

WellCare is committed to identifying, investigating and remedying fraud, waste and abuse (FWA), as further detailed in the Company’s FWA Policy. To this end, WellCare continues to implement policies and procedures to detect fraud, particularly regarding claim coding, to ensure that are practices are consistent with the highest industry standards.

WellCare’s goal is to process claims consistently and in accordance with best practice standards. If a claim coding is identified as contrary to AMA, CMS, FDA and State Medicaid guidelines, the Provider will be notified of the same, and WellCare will seek to remedy the issue. Providers will receive notification that claim coding error was detected based on edits that include, but are not limited to, AMA, CMS, FDA and state Medicaid guidelines. That includes high-dollar claims, unbundled procedures, modifiers, Correct Coding Initiatives edits, duplicates, maximum units, multiple surgeries, and bilateral procedures, all of which WellCare actively monitors for FWA.

Federal and state regulatory agencies, law enforcement, and WellCare vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, upcoding 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 Medicaid managed care organization meet annual compliance and education training requirements with respect to 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.

To report suspected fraud and abuse, please refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid or call the confidential and toll-free WellCare compliance hotline. Details of the corporate ethics and compliance program, and how to contact the WellCare fraud hotline, are on WellCare’s website at www.wellcare.com/Florida/Corporate/Compliance.

To report suspected fraud and/or abuse in Florida CMS Health Plan, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form which is available online at apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx.

If a Provider reports suspected fraud and the report results in a fine, penalty, or forfeiture of property from a doctor or other healthcare Provider, the Provider may be eligible for a reward through the Attorney General’s Fraud Rewards Program. Call toll-free at 1-866-966-7226 or 1-850-414-3990. The reward may be up to 25% of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). Providers can talk to the Attorney General’s Office about keeping their identity confidential and protected.

Confidentiality of Member Information and 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, as may be amended. 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), 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). The NPP advises Members how the Provider practice may use and share a Member’s PHI and how a Member can exercise his or her health privacy rights. HIPAA provides for the release of Member medical records to WellCare for payment purposes and/or health plan operations.
HIPAA regulations require each covered entity, such as healthcare Providers, to provide a NPP to each new patient or Member. 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 Provider regarding the Member’s medical care and treatment
- All personal and/or protected health information (PHI) 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 behavioral 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, behavioral or psychiatric problem

Refer to Section 3: Quality Improvement for guidance in responding to WellCare’s requests for Member health records for the purposes of treatment, payment and healthcare activities.

**Disclosure of WellCare Information to CMS Health Plan Members**

Periodically, Members may inquire as to the operational and financial nature of their health plan. This request may be made verbally or in writing. We will provide that information to the Member upon request.

For more information on how to request this information, Members may contact CMS Health Plan’s Customer Service using the toll-free telephone number found on the Member’s ID card. Providers may contact CMS Health Plan’s Provider Services by referring to the *Quick Reference Guide* on WellCare’s website at [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid).
Section 9: Delegated Entities

Overview
WellCare may, by written contract, delegate certain functions under WellCare’s contracts with CMS and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales & marketing, utilization management, quality management, case management, disease management, claims processing, credentialing, network management, provider appeals, and customer service. WellCare may delegate all or a portion of these activities to another entity (a Delegated Entity).

WellCare oversees the provision of services provided by the Delegated Entity and/or sub-delegate, and is accountable to federal and state agencies for the performance of all delegated functions. It is the ultimate 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.

Delegation Oversight Process
WellCare’s Delegation Oversight Committee (DOC) was formed to provide oversight for all subcontracted vendors where specific services are delegated to an entity. WellCare defines a “delegated entity” as a subcontractor which performs a core function under one of WellCare’s government contracts. The Delegation Oversight Committee is chaired by the Sr. Director, Corporate Compliance. The committee members include appointed representatives from the following areas: Corporate Compliance, Legal, Shared Services Operations, Clinical Services Organization, and a market representative from each Regional Area. The Chief Compliance Officer has ultimate authority as to the composition of the Delegation Oversight Committee membership. The Delegation Oversight Committee will hold monthly meetings or more frequently as circumstances dictate.

Refer to Section 8: Compliance of this Manual for additional information regarding compliance requirements.

WellCare monitors compliance through the delegation oversight process and the Delegation Oversight Committee by:

- Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs
- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity’s ability to perform the delegated function
- Providing guidance on written agreement standards with delegated entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity
- Conducting ongoing monitoring activities to evaluate an entity’s performance and compliance with regulatory and accreditation requirements
- Conducting annual audits to verify the entity’s performance and processes support sustained compliance with regulatory requirements and accreditation standards
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity’s performance is substandard or terms of the agreement are violated
- Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the
expectations of the current contractual agreement and regulatory requirements of WellCare’s Medicare and Medicaid program
• Track and trend internal compliance with oversight standards, entity performance, and outcomes
Section 10: Behavioral Health

Overview
WellCare provides a behavioral health benefit for CMS Health Plan. All provisions contained within the Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Members may refer themselves for behavioral health services and do not require a referral from their PCP.

Some behavioral health services may require Prior Authorization, including all services provided by non-participating Providers. WellCare uses InterQual, Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) criteria for behavioral health, and American Society for Addiction Medicine (ASAM) criteria, for substance use disorder. These criteria are well-known and nationally accepted guidelines for assessing level of care criteria for behavioral health.

For complete information regarding benefits and exclusions, or in the event a Provider needs to contact WellCare’s Customer Service for a referral to a behavioral health Provider, refer to the Quick Reference Guide, which may be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

Behavioral Health Program
WellCare does not require Prior Authorization for standard outpatient Services. WellCare encourages community-based services and Member treatment at the least restrictive level of care, whenever possible.

Prior Authorization is required for psychological testing, intensive outpatient, partial hospital programs, residential treatment programs and inpatient hospital services. Prior authorization request forms for all levels of care are made available to Providers online or upon request. For complete information regarding authorization requirements please visit the behavioral health link on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid/Behavioral-Health.

Continuity and Coordination of Care between Medical Care and Behavioral Healthcare
PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, Behavioral Health Providers may provide physical healthcare services if and when they are licensed to do so within the scope of their practice. Behavioral Health Providers are required to use the ICD-10 or current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) when assessing the Member for behavioral health services and document the diagnosis and assessment/outcome information in the Member’s medical record.

Behavioral Health Providers are required to submit, with the Member’s or Member’s legal guardian’s consent, an initial and quarterly summary report of the Member’s behavioral health status to the PCP. Communication with the PCP should occur more frequently, if clinically indicated. WellCare encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization (WellCare recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to...
the PCP). Please send this communication, with the properly signed consent, to the Members identified PCP noting any changes in the treatment plan on the day of discharge.

We strongly encourages open communication between PCPs and behavioral health Providers to help guide and ensure the delivery of safe, appropriate, efficient and quality clinical healthcare. If a Member’s medical or behavioral condition changes, we expect that both PCPs and behavioral health Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers.

Effective communication of care is dependent upon clear and timely communication and allows for better decision making regarding treatment interventions, decreases the potential for fragmentation of treatment and improves Member health outcomes.

To maintain continuity of care, patient safety and Member well-being, communication between behavioral healthcare Providers and medical care Providers is critical, especially for Members with comorbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and thus impact Member outcomes.

**Responsibilities of Behavioral Health Providers**

WellCare monitors Providers against these standards to ensure Members can obtain needed health services within the acceptable appointments waiting times. The provisions below are applicable only to Behavioral Health Providers and do not replace the provisions set forth in **Section 2: Provider and Member Administrative Guidelines** for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH Provider – Urgent</td>
<td>Within 48 hours of the request</td>
</tr>
<tr>
<td>BH Provider – Sick Care</td>
<td>Within 14 days of the request</td>
</tr>
<tr>
<td>BH Provider – Well Care Visit</td>
<td>Within 14 days for an initial appointment and 30 days for a standard follow-up</td>
</tr>
</tbody>
</table>

All Members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place, and name of the Provider to be seen. The outpatient treatment must occur within seven days from the date of discharge and should include medication monitoring, if needed.

In the event that a Member misses an appointment, the Behavioral Health Provider must contact the Member within 24 hours to reschedule.

Behavioral Health Providers are expected to assist Members in accessing emergent, urgent, and routine behavioral services as expeditiously as the Member’s condition requires. Members also have access to a toll-free behavioral crisis hotline that is staffed 24 hours a day. The behavioral crisis phone number is printed on the Member’s card and is available on WellCare’s website. The behavioral health crisis hotline phone number is also available in the Quick Reference Guide located at [www.wellcare.com/en/Florida/Providers/Medicaid](http://www.wellcare.com/en/Florida/Providers/Medicaid).
For information about WellCare’s Case Management and Disease Management programs, including how to refer a Member for these services, please see Section 4: Utilization Management, Case Management and Disease Management.
Section 11: Pharmacy

Overview
WellCare’s pharmaceutical management procedures are an integral part of the pharmacy program that ensure and promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of its Members. The utilization management tools that are used to optimize the pharmacy program include:

- Preferred Drug List (PDL)
- Mandatory Generic Policy
- Step Therapy (ST)
- Quantity Limit (QL)
- Age Limit (AL)
- Coverage Determination Review Process
- Pharmacy Lock-In Program
- Network Improvement Program (NIP)
- Exactus™ Pharmacy Solutions

These processes are described in detail below. In addition, prescriber and Member involvement is critical to the success of the pharmacy program. To help your patient get the most out of their pharmacy benefit please consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, i.e., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) Hypertension guidelines
- Prescribe drugs listed on the PDL
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class
- Evaluate medication profiles for appropriateness and duplication of therapy

To contact WellCare’s Pharmacy department, please refer to the Quick Reference Guide which may be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

Preferred Drug List
For WellCare’s CMS Health Plan, WellCare has adopted the Agency’s Medicaid Preferred Drug List (PDL) and provide all prescription drugs and dosage forms listed therein.

The PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmacy and Therapeutics Committee (P&T Committee). MMA Managed Care Plans and Comprehensive Managed Care Plans provide all prescription drugs listed in the Agency’s Medicaid Preferred Drug List (PDL). The Managed Care Plans also participate in the Agency’s Pharmaceutical and Therapeutics Committee, as requested by the Agency. The PDL denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

Drugs are selected based on the drug’s efficacy, safety, side effects, pharmacokinetics, clinical literature and cost effectiveness profile. The medications on the PDL are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, age limitation, Prior Authorization or step therapy).
The CMS Health Plan PDLs can be found on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid/Pharmacy.

Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to Providers via the following:

- Quarterly updates in Provider newsletters
- Website updates, including P&T PDL Change notices
- Pharmacy and Provider communication that detail any major changes to a particular therapy or therapeutic class

**Additions to the Preferred Drug List**

To request consideration for the addition of a drug to CMS Health Plan’s PDL, Providers may write or fax explaining the medical justification. For contact information, refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

For more information on requesting exceptions, refer to the Coverage Determination Review Process below.

**Generic Medications**

The use of generic medications is a key pharmaceutical management tool. Generic drugs are equally effective and generally less costly than their brand name counterparts. Their use can contribute to cost-effective therapy.

Generic drugs must be dispensed by the pharmacist when listed on the PDL. A Coverage Determination Request Form should be completed and submitted to our pharmacy department along with clinical justification when requesting a non-PDL branded medication as well as when requesting a brand name medication when the generic is available on the PDL.

For more information on the Coverage Determination Review Process, including how to access the Coverage Determination Request form, see Coverage Determination Review Process below.

**Step Therapy**

Step therapy programs are developed by the P&T Committee. These programs are designed to encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before stepping up to less cost-effective alternatives.

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on the Agency’s PDL have been evaluated through the use of clinical literature and are approved by the corresponding P&T Committee.

Medications requiring step therapy are identified on the PDL.
**Quantity Limits**  
Quantity limits are used to ensure that pharmaceuticals are supplied in a quantity consistent with Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits are also used to help prevent billing errors.

Please refer to the PDL to view drugs with quantity limits.

**Age Limits**  
Some drugs have an age limit associated with them. We use age limits to help ensure proper medication utilization and dosage, when necessary.

Medications with age limits are identified on the PDL.

**Injectable and Infusion Services**  
Select self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Some self-injectable products and infusion drugs listed on the PDL and all non-PDL injectables will require a Coverage Determination Request Review using the Injectable Infusion Form.

Approved self-injectable and infusion drugs are covered when supplied by retail pharmacies and infusion vendors contracted with WellCare. Please contact the Pharmacy department regarding criteria related to specific drugs. The specific J-codes of any self-injectable products that do not require authorization when administered in a doctor’s office are included on the No Authorization Required Medical Injectable List.

Refer to our website at [www.wellcare.com/Florida/Providers/Medicaid/Pharmacy](http://www.wellcare.com/Florida/Providers/Medicaid/Pharmacy) for more information. For Medical Injectables that require authorization refer to the authorization look-up tool [www.wellcare.com/Florida/Providers/Authorization-Lookup](http://www.wellcare.com/Florida/Providers/Authorization-Lookup). Providers may access the Injectable Infusion Form in the Forms and Documents section on the Provider Resources page [www.wellcare.com/en/Florida/Providers/Medicaid/Forms](http://www.wellcare.com/en/Florida/Providers/Medicaid/Forms).

**Coverage Limitations**  
We cover all drug categories currently available through the Florida Medicaid Fee-For-Service program. The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- Agents used for anorexia, weight gain or weight loss
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Cough and cold combination medications for Members 21 years of age and older
- Drugs for the treatment of erectile dysfunction
- DESI drugs or drugs that may have been determined to be identical, similar or related
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted

We will not reimburse for prescriptions for early refills, duplicate therapy or excessively high dosages for the Member.
**Hemophilia Medications**

CMS Health Plan benefits cover hemophilia factor-related medications. CMS Health Plan coordinates the care of its Members with the Agency-approved organizations during operation of the Comprehensive Hemophilia Disease Management Program.

**Informed Consent for Psychotropic Medications**

All prescriptions for psychotropic medications prescribed for a child under the age of 13 must be accompanied by the express, written and informed consent of the child’s parent or legal guardian. Psychotropic (psychotherapeutic) medications include antipsychotics, antidepressants, antianxiety medications, and mood stabilizers. Anticonvulsants and attention-deficit/hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included at this time. For purposes of this Manual, and pursuant to Florida statute 394.492(3), “child” means a person from birth until the person’s 13th birthday.

The prescriber must document the consent in the child’s medical record and provide the pharmacy with a signed attestation of the consent with the prescription. The prescriber must ensure completion of an appropriate attestation form.

The completed form must be filed with the prescription (hard copy or imaged) in the pharmacy and held for audit purposes for a minimum of six years. Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form. Every new prescription will require a new informed consent form. The informed consent forms do not replace Prior Authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents from birth through age 17.

The consent/attestation form is located on our website at:

**Children's Medical Services Health Plan | WellCare**

For the full Agency Healthcare Alert and Provider Message, including a list of Psychotropic (Psychotherapeutic) Medications, step-by-step instructions and consent forms, refer to the Agency’s website at [ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml](ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml).

**Over-the-Counter (OTC) Medications**

OTC items listed on the PDL require a prescription. All other OTC items offered as an expanded benefit by CMS Health Plan do not require a prescription. Examples of OTC items listed on the PDL include:

- Multivitamins/multivitamins with iron
- Iron
- Non-sedating antihistamines
- Enteric coated aspirin
- Diphenhydramine
- Insulin & insulin syringes
- Topical antifungals
- Ibuprofen
- Permethrin
- Meclizine
- Urine test strips
- H-2 receptor antagonists

For a complete listing of covered OTC medications, please refer to the PDL on our website at [www.wellcare.com/Florida/Providers/Medicaid/Pharmacy](www.wellcare.com/Florida/Providers/Medicaid/Pharmacy).
Pharmacy Lock-In Program
Members identified as overutilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple physicians, or frequently visiting the Emergency Room seeking pain medication will be placed in Pharmacy Lock-in (Lock-in) status for a minimum of one year. While in Lock-in, the Member will be restricted to one prescriber and one pharmacy to obtain their medications. Claims submitted by other pharmacies will not be paid for the Member. Members identified will also be referred for case management. The Care Management team will work with the Member to create an individualized Care Plan. Care managers provide monitoring, education, communication and collaboration, and can assist with access to alternative treatments to improve a Member’s health. For questions or concerns regarding the Lock-in program, Members or Providers may call 1-866-799-5321, Monday–Friday, 8 a.m. to 7 p.m. Eastern. TTY/TDD users may call 711.

Coverage Determination Review Process (Requesting Exceptions)
The goal of the Coverage Determination Review program (also known as Prior Authorization) is to ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications. The Coverage Determination Review process is required for:

- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limit
- Most self-injectable and infusion medications (including chemotherapy)
- Drugs not listed on the PDL
- Drugs that have an age edit
- Drugs listed on the PDL but still require Prior Authorization
- Brand-name drugs when a generic exists
- Drugs that have a step therapy edit and the first-line therapy is inappropriate

Providers may request an exception to CMS Health Plan’s PDL verbally or in writing. For written requests, Providers should complete a Coverage Determination Request Form, supplying pertinent Member medical history and information. A Coverage Determination Request form may be accessed on our website at www.wellcare.com/Florida/Providers/Medicaid/Forms.

To submit a request, orally, refer to the contact information listed on your Quick Reference Guide on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

If Authorization cannot be approved or denied, and the drug is Medically Necessary, up to a seven-day emergency supply of the non-preferred drug can be supplied to the Member.

Prior Authorization protocols are developed and reviewed at least annually by the P&T Committee. These 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), allergic reaction to preferred product, etc.).

Medication Appeals
To request an appeal of a Coverage Determination Review decision, contact the Pharmacy Appeals department via fax, mail, in person or phone. The Medication Appeals Form is located on the website at www.wellcare.com/Florida/Providers/Medicaid/Forms.
For contact information, refer to the *Quick Reference Guide* on our website at www.wellcare.com/Florida/Providers/Medicaid.

Once the appeal of the Coverage Determination Review decision has been properly submitted and obtained by WellCare, the request will follow the appeals process described in *Section 7: Appeals and Grievances* section of this Manual.

**Pharmacy Management – Network Improvement Program (NIP)**
The Pharmacy Network Improvement Program (NIP) is designed to provide physicians with quarterly utilization reports to identify overutilization and underutilization of pharmaceutical products. The reports will also identify opportunities for optimizing best practice guidelines and cost-effective therapeutic options. These reports are delivered by the state Pharmacy Director and/or Clinical Pharmacy Manager to physicians identified for the program.

**Member Pharmacy Access**
WellCare maintains a comprehensive network of pharmacies to ensure that pharmacy services are available and accessible to all Members 24 hours a day.

For areas where there are no pharmacies open 24 hours a day, Members may call CVS/Caremark™ for information on how to access pharmacy services. Contact information is located on the *Quick Reference Guide* on WellCare’s website at www.wellcare.com/Florida/Providers/Medicaid.

**Exactus Pharmacy Solutions**
WellCare offers specialty pharmacy services to Members who are taking medications to treat long-term, life-threatening or rare conditions. The Exactus Pharmacy Solutions team has expertise in the special handling, storage and administration that injectables, infusibles, orals and other medications require. This team knows the insurance process and the Member’s plan benefits. This means less chance of delays in a Member receiving their needed medication(s). Prescription orders generally ship directly to the Member’s home, Provider’s office, or alternative address provided by the Member, within 24 to 48 hours after contacting an Exactus Pharmacy Solutions representative. The actual ship date depends on whether or not Provider discussion is needed about the prescription.

To learn more about the conditions covered under Exactus Pharmacy Solutions, or how to contact them, refer to the Exactus Pharmacy Solutions website at www.wellcare.com/Exactus-Specialty-Pharmacy.
Section 12: Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the WellCare Participation Agreement.

**Advance Directive** means a written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of healthcare when the individual is incapacitated.

**Adverse Benefit Determination** means, pursuant to 42 CFR 438.400(b). the 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; or the failure of WellCare to act within 90 days from the date WellCare receives a grievance, or 30 days from the date WellCare receives an appeal. For a resident of a rural area with only one managed care entity, the denial of an enrollee’s request to exercise the right to obtain services outside the network; and the denial of an enrollee’s request to dispute a financial liability.

**Agency** means state of Florida, Agency for Health Care Administration.

**Appeal** means a formal request from an enrollee to seek a review of an adverse benefit determination taken by WellCare pursuant to 42 CFR 438.400(b).

**Authorization** means an approval request for payment of services. An authorization is provided only after WellCare agrees the treatment is necessary.

**Behavioral Health Home** means that a Community Mental Health Center has been approved to provide both behavioral health services and primary medical services to members onsite or in close collaboration. Providers must submit a Readiness Review Tool and be approved by the Health Plan to become a designated Behavioral Health Home.

**Benefit Plan** means a schedule of healthcare services to be delivered or other health Covered Service 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.

**Business Days** means traditional workdays, which are Monday–Friday. Federal and/or state holidays may be excluded.

**Calendar Days** means all seven days of the week.

**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 radiology, laboratory, dental, vision or hearing services.

**Centers for Medicare & Medicaid Services (CMS)** means the agency within the U.S. Department of Health & Human Services that provides administration and funding for Medicare.
under Title XVIII, Medicaid under Title XIX, and the State Children’s Health Insurance Program under Title XXI of the Social Security Acts.

**Children/Adolescents** means Members younger than age of 21. For purposes of the provision of Behavioral Health services, means Members under the age of 18 as defined by the Department of Children and Families (DCF).

**Children’s Health Insurance Program (CHIP)** refers to the medical assistance program authorized by Title XXI of the Social Security Act.

**Children’s Medical Services Health Plan (CMS Plan/DOH)** refers to a CHIP health plan authorized in Chapter 409, Part II, F.S. for children with chronic conditions operated by the Florida Department of Health’s Children’s Medical Services under contract with WellCare (Provider). A Medicaid Specialty Plan for children with chronic conditions operated by the Florida Department of Health’s Children’s Medical Services as specified in section 409.974(4), F.S., through a single, statewide Contract with AHCA that is not subject to the Statewide Medicaid Managed Care program (SMMC) procurement requirements, or regional plan limits, but must meet all other plan requirements for the Managed Medical Assistance (MMA) program. The Medicaid Specialty Plan described herein is operated by the Florida Department of Health’s Children’s Medical Services under contract with WellCare (Provider).

**Clean Claim** means a claim for Covered Services that a) is received timely by WellCare, b) can be processed without obtaining additional information from the Provider of the service or from a third party, and c) is not subject to coordination of benefits or subrogation issues. It includes a claim with errors originating in a state’s claims system. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity pursuant to 42 CFR 447.45.

**CLIA** means the federal legislation commonly known as the Clinical Laboratories Improvement Amendments of 1988 as found at Section 353 of the federal Public Health Services Act (42 U.S.C. § 201, 263a) and regulations promulgated hereunder.

**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 items and services covered under a Benefit Plan.

**Department of Children and Families (DCF)** means state of Florida, Department of Children and Families.

**Department of Health** refers to the State agency responsible for public health, public primary care and personal health, disease control, and licensing of health professionals, including Children’s Medical Services as specified in section 409.974(4), F.S (CMS Plan)

**EPSDT** means Early and Periodic Screening, Diagnosis and Treatment program that provides Medically Necessary healthcare, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 U.S.C. § 1396d(r)(5) and 42 CFR 440.40(b)(2012) or its successive regulation, to all Members under the age of 21.
**Emergency Medical Condition** means (a) a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes (see Section 395.002, F.S.).

**Emergency Services and Care** means medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists. If such a condition exists, Emergency Services and care include the care or treatment necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the facility.

**Encounter Data** means a record of Covered Services provided to a WellCare Member. An “encounter” is an interaction between a patient and Provider (WellCare, rendering physician, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient.

**Expanded Benefits** are benefits that the Health Plan received approval from AHCA to provide members that are above and beyond the traditional Medicaid Services.

**Grievance** means an expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a Provider or WellCare employee or failure to respect the enrollee’s rights, or an enrollee dispute of an extension of time proposed by the Managed Care Plan to make an authorization decision.

**ICD-10-CM** means *International Classification of Diseases, 10th Revision, Clinical Modification*

**In Lieu of Services** means services that the Health Plan has been approved by AHCA to provide to members in lieu of or in substitution to a traditional Medicaid service.

**Ineligible Person** means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Healthcare Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement 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 Healthcare 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 non-procurement programs as determined by a State Governmental Authority.
LTAC means a Long-Term Acute Care hospital.

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

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 co-payments, coinsurance, deductibles or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

Members/Individuals with Special Healthcare 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.

Out-of-Network means a Provider is not contracted with WellCare.

Periodicity means the frequency with which an individual may be screened or re-screened.

Periodicity Schedule means the schedule which defines age-appropriate services and timeframes for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program.

Preferred Drug List (PDL) means a list of drugs that has been put together by doctors and pharmacists.

Primary Care Provider (PCP) means a contracted Provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

Prior Authorization means the act of authorizing specific services before they are rendered.

Provider means a person or entity eligible to provide Medicaid services and that has a contractual agreement with WellCare to provide services. PSN Fee-For-Service Providers must have an active Medicaid Provider agreement. All other Providers must be eligible for a Medicaid Provider agreement.

Referral means a request by a PCP for a Member to be evaluated and/or treated by a specialty physician.
**Routine Care** means the level of care that can be delayed without anticipated deterioration in the Member’s condition.

**Screening** means an Assessment of an enrollee's physical or mental condition to determine evidence or indications of problems and need for further evaluation.

**Service** means healthcare, treatment, a procedure, supply, item or equipment.

**Service Location** means any location at which a Member may obtain any healthcare service covered by WellCare under the terms of the Provider Contract.

**Urgent Care** means services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or could substantially restrict an enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

**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.
# Section 13: CMS Health Plan Resources

## Important Telephone Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service/Provider Service</td>
<td>1-866-799-5321</td>
</tr>
<tr>
<td>TTY</td>
<td>1-877-247-6272</td>
</tr>
<tr>
<td>24-Hour Nurse Advice Line</td>
<td>1-800-919-8807</td>
</tr>
<tr>
<td>24-Hour Behavioral Health Crisis Line</td>
<td>1-855-606-3622</td>
</tr>
<tr>
<td>Fraud, Waste and Abuse Hotline</td>
<td>1-866-678-8355</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>1-407-551-3200, option</td>
</tr>
<tr>
<td>Operations Account Resolution</td>
<td><a href="mailto:FloridaProviderRelations@wellcare.com">FloridaProviderRelations@wellcare.com</a></td>
</tr>
<tr>
<td>To report abuse, neglect or exploitation</td>
<td>Florida Abuse Hotline: 1-800-96-ABUSE</td>
</tr>
<tr>
<td></td>
<td>(1-800-962-2873)</td>
</tr>
<tr>
<td></td>
<td>(TTY 1-800-453-5145)</td>
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<tr>
<td></td>
<td>Providers can also report abuse through the DCF website: <a href="http://www.dcf.state.fl.us/abuse/report/">www.dcf.state.fl.us/abuse/report/</a></td>
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</tbody>
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## Forms and Documents

- [www.wellcare.com/Florida/Providers/Medicaid/Forms](http://www.wellcare.com/Florida/Providers/Medicaid/Forms)

## Quick Reference Guide

- [www.wellcare.com/en/Florida/Providers/Medicaid](http://www.wellcare.com/en/Florida/Providers/Medicaid)

## Clinical Practice Guidelines and Clinical Coverage Guidelines

- [www.wellcare.com/Florida/Providers/Clinical-Guidelines](http://www.wellcare.com/Florida/Providers/Clinical-Guidelines)

## Job Aids and Resource Guides

- [www.wellcare.com/Florida/Providers/Medicaid](http://www.wellcare.com/Florida/Providers/Medicaid)

## Provider Orientation

- [www.wellcare.com/Florida/Providers/Getting-Started/Secure-Portal](http://www.wellcare.com/Florida/Providers/Getting-Started/Secure-Portal)

Provider must be a registered user of WellCare’s secure online Provider Portal to access.
Quality care is a team effort.
Thank you for playing a starring role!