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Section 1: Overview

About WellCare
WellCare Health Plans, Inc., (WellCare) provides managed care services targeted to
government-sponsored health care programs, focused on Medicaid and Medicare,
including prescription drug plans and health plans for families, and for aged, blind and
disabled people. WellCare’s corporate office is located in Tampa, Florida. As of
September 30, 2014, WellCare served approximately 4 million members.

WellCare of Kentucky, Inc., contracted with the Kentucky Cabinet for Health and Family
Services, Department for Medicaid Services (the Department) to provide Medicaid and
Kentucky Children’s Health Insurance Program (KCHIP) managed care services in
seven of the state’s eight regions beginning Nov. 1, 2011. On Jan. 1, 2013, WellCare
began providing managed care services statewide. WellCare’s experience and
commitment to government-sponsored health care programs enables WellCare to serve
its members and providers as well as manage its operations effectively and efficiently.

Mission and Vision
WellCare’s vision is to be the leader in government-sponsored health care programs in
partnership with the members, providers, governments and the communities it serves. WellCare will:
- Enhance its members’ health and quality of life;
- Partner with providers and governments to provide quality, cost-effective health
care solutions; and
- Create a rewarding and enriching environment for its associates.

WellCare's Values are:
- Partnership – Members are the reason WellCare is in business; providers are
WellCare’s partners in serving its members; and regulators are the stewards of
the public’s resources and trust. WellCare will deliver excellent service to its
partners.
- Integrity – WellCare’s actions must consistently demonstrate a high level of
integrity that earns the trust of those it serves.
- Accountability – All associates must be responsible for the commitments they
make and the results WellCare delivers.
- Teamwork – WellCare and its associates can expect – and are expected – to
demonstrate a collaborative approach in the way they work.

Purpose of this Manual
This Provider Manual is intended for WellCare-contracted (participating) Medicaid
providers providing health care service(s) to WellCare members enrolled in a WellCare
Medicaid Managed Care Plan. This Manual serves as a guide to the Policies and
Procedures governing the administration of WellCare’s Medicaid plans and is an
extension of and supplements the Provider Participation Agreement (Agreement)
between WellCare and health care providers who include, without limitation: physicians,
hospitals and ancillary providers (collectively, providers). This Manual replaces and
supersedes any previous versions prior to the Department's approval date of
March 25, 2013 and is available on WellCare’s website at
In accordance with the Policies and Procedures clause of the Agreement, participating WellCare Medicaid 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.

**WellCare’s Medicaid Managed Care Plans**
WellCare provides Medicaid and CHIP managed care services in the Commonwealth of Kentucky (Commonwealth). These products are offered in select markets to allow flexibility and offer a distinct set of benefits to fit member needs in each area. For product information, please refer to the Quick Reference Guide on WellCare’s website at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources).

**Eligibility**
Eligibility for Kentucky’s Medicaid program is solely determined by the Department. Upon determination of eligibility, Kentucky Medicaid recipients will be enrolled with a Medicaid Managed Care Plan, provided the following conditions are met:
- The individual must reside within a Medicaid managed care region; and
- The individual must qualify to receive Medicaid assistance under one of the aid categories defined by the Department.

Individuals eligible for Kentucky Medicaid can be categorized into:
- Families and Children; and
- Aged, Blind or Disabled (ABD).

The Families and Children population is comprised of children, pregnant women and caretaker relatives. The ABD population is comprised mostly of individuals with disabilities or those who are 65-years-old or older.

Eligible Medicaid recipients to be enrolled into a Medicaid Managed Care Organization (MCO), such as WellCare, include Families and Children, Pregnant Women and ABD eligible people as well as children enrolled in the Kentucky Children’s Health Insurance Program (KCHIP). Certain members who are eligible for Medicaid, including those eligible for both Medicaid and Medicare, children in foster care and children with disabilities, may be voluntarily enrolled into a Medicaid MCO, but may not be enrolled on a mandatory basis without a waiver from the Centers for Medicare & Medicaid Services (CMS).

For more information on Medicaid assistance, refer to the Kentucky Department for Medicaid Services website at [http://chfs.ky.gov/dms/](http://chfs.ky.gov/dms/).
Core Benefits and Services
As of the date of publication of this Manual, the following Covered Services are provided as medically necessary to WellCare’s Kentucky Medicaid members:

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<thead>
<tr>
<th>Benefit/Service</th>
<th>Notes/Limits</th>
<th>Non-Region 3</th>
<th>Region 3 Counties</th>
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<tr>
<td>After School/Summer Program Service</td>
<td>Rehabilitative and therapeutic activities that focus on the development of appropriate behaviors and social skills</td>
<td></td>
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<tr>
<td>Allergy Services</td>
<td>Covers both adults and children</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Alternative Birthing Center</td>
<td>Prenatal visits as appropriate Necessary supplies and material Post-delivery exam Postnatal visits Lab services</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Alternative Birthing Center – Postnatal</td>
<td>2 postnatal visits within 6 weeks of delivery</td>
<td></td>
<td></td>
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<tr>
<td>Ambulatory Surgical Centers (ASC)</td>
<td></td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Behavioral Health – Crisis Stabilization Services</td>
<td>Up to 10 consecutive days in a therapeutic environment that provides for the comprehensive assessment, diagnosis and treatment of complex behavioral health needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Includes mental health rehabilitation/stabilization, behavioral support and psychological services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Behavioral Health Services – Intensive Outpatient</td>
<td>A structured program of individual and group therapeutic activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Services – Psychotherapy</td>
<td>Individual, family and group psychotherapy sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical and Vaginal Cancer Screening</td>
<td>Pap tests, pelvic exams 1 procedure per year, unless more are needed</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Benefit/Service</td>
<td>Notes/Limits</td>
<td>Non-Region 3</td>
<td>Region 3 Counties</td>
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<tr>
<td>Chiropractic Services</td>
<td>Restrictions may apply</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Community Mental Health Center (CMHC) Services</td>
<td>An inpatient therapeutic program for members requiring full-time care when no other service of the center is appropriate</td>
<td>$0 per admission</td>
<td>$0 per admission</td>
</tr>
</tbody>
</table>
| Dental Services – Adults Age 21 and Older | • 1 dental visit each 12-month period per provider  
• 1 oral exam each 12-month period  
• 2 oral exams for members <21 if in conjunction with a cleaning  
• 2 cleanings each 12-month period for members <21  
• 1 cleaning each 12-month period  
• 1 set of X-rays each 12-month period  
• Extractions and fillings | $0           | $0               |
| Dental Services – Children Younger Than 21 | • 1 dental visit each 12-month period per provider  
• 1 oral exam each 12-month period  
• 2 oral exams for members <21 if in conjunction with a cleaning  
• 2 cleanings each 12-month period for members <21  
• 1 cleaning each 12-month period  
• 1 set of X-rays each 12-month period  
• Extractions and fillings | $0 co-pay for child preventive services | $0 co-pay for child preventive services |
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<th>Benefit/Service</th>
<th>Notes/Limits</th>
<th>Non-Region 3</th>
<th>Region 3 Counties</th>
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<td>Dialysis – End Stage Renal Disease (ESRD)</td>
<td>Services and procedures designed to promote and maintain the functioning of the kidney and related organs</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Covered per item</td>
<td>$0</td>
<td>$0</td>
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<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Birth to 2 years: 1 exam at birth (neonatal examination) and 1 exam at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months of age; 1 exam each year for children ages 3–20</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>• Covered per visit • Emergency • Non-emergency</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Available to all persons of child-bearing age; provided through routine physician visits or through family planning clinics</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td></td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Limited to children under 21 Includes assessment for hearing aid, fitting, orientation and repair Not to exceed $800 per ear every 36 months 1 audiologist visit per calendar year</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Limited to children under 21 1 complete hearing evaluation per calendar year</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Benefit/Service</td>
<td>Notes/Limits</td>
<td>Non-Region 3</td>
<td>Region 3 Counties</td>
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<tr>
<td><strong>Home Health Care Services</strong></td>
<td>Includes skilled nursing services, home health aide services and physical, speech and occupational therapy services. Up to 25 visits each calendar year.</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Hospice – Non-Institutional</strong></td>
<td>Available to terminally ill members with a life expectancy of 6 or fewer months</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Hospital Services – Inpatient Medical</strong></td>
<td></td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Hospital Services – Inpatient Mental Health</strong></td>
<td></td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Hospital Services – Outpatient</strong></td>
<td></td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Human Immunodeficiency Virus (HIV) Screening</strong></td>
<td>Covered for members who are pregnant or at increased risk for the infection, including anyone who asks for the test</td>
<td></td>
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</tr>
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<td><strong>Immunizations</strong></td>
<td>Includes immunizations and vaccines for adults and children</td>
<td>$0</td>
<td>$0</td>
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<td><strong>Kidney Dialysis and Transplants</strong></td>
<td></td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Laboratory Diagnostic and Radiology Services</strong></td>
<td>By physician or lab</td>
<td>$0</td>
<td>$0</td>
</tr>
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<td><strong>Maternity Services</strong></td>
<td>Nurse midwife services; pregnancy-related services; services for other conditions that might complicate pregnancy; 60 days postpartum pregnancy-related services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Maternity Services – Ultrasound</strong></td>
<td>2 per 9 month period, unless more are needed</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Benefit/Service</td>
<td>Notes/Limits</td>
<td>Non-Region 3</td>
<td>Region 3 Counties</td>
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<tr>
<td>Meals and Lodging</td>
<td>Covered for appropriate escorts of members to obtain covered medical services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Nursing Facility Services</td>
<td>Facility services are only covered for individuals with mental retardation or a developmental disability Services for both categorically needy and medically needy members</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>To promote health and reduce risk associated with dietary factors</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery</td>
<td>To correct diseases, injuries and defects in the head, neck, jaws, and hard and soft tissues of the mouth, jaws and face, skull, as well as associated structures</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Physician Office Services</td>
<td>Primary care physicians (PCPs), specialists, physician assistants, nurse practitioners, nurse midwives, office visits, medical/surgical care and consultation, diagnosis and treatment</td>
<td>$0</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Routine foot care is not covered except for certain conditions that require professional supervision</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>For members who do not have Medicare, restrictions may apply.</td>
<td>Unlimited $0 for generic</td>
<td>Unlimited $0 for preferred brand</td>
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<td></td>
<td></td>
<td>$0 for preferred brand</td>
<td>$4 for non-preferred brand</td>
</tr>
<tr>
<td>Preventive Services (Wellness Care)</td>
<td>Wellness visits</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Benefit/Service</td>
<td>Notes/Limits</td>
<td>Non-Region 3</td>
<td>Region 3 Counties</td>
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<tr>
<td>Primary Care Center (PCC)</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td></td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>Per item</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facilities (PRTFs)</td>
<td>Children ages 6 through 12 who need intensive treatment and a more highly structured environment than they can receive in family- and other community-based alternatives to hospitalization</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Rural Health Clinics (RHC)</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td></td>
</tr>
<tr>
<td>Second Opinion</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td></td>
</tr>
<tr>
<td>Specialized Children’s Services Clinics</td>
<td>Child sexual abuse medical exam is covered if medically necessary and provided to a recipient who is under the age of 18</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Coverage includes pregnant women, and children, and adults</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Benefit/Service</td>
<td>Notes/Limits</td>
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</table>
| Targeted Case Management Services     | Behavioral health services that include a minimum of 4 sessions in 1 month, including:  
  - 1 face-to-face contact with the recipient  
  - 1 face-to-face contact with the parent, family member, guardian or other person who has custodial control or supervision of the recipient; and  
  - 2 additional contacts which may be by telephone or face-to-face with the recipient or on behalf of the recipient | $0           | $0               |
| Telemedicine                          | The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance | $0 per service | $0 per service   |
| Therapeutic Group Residential Service | Services in a therapeutic environment with 24-hour supervision and treatment in a group residential facility                                                                                             | $0           | $0               |
| Therapy – Physical, Speech, Occupational | Up to 20 visits per calendar year  
  $0 physical  
  $0 speech  
  $0 occupational | $0 physical  
  $0 speech  
  $0 occupational |
| Tobacco Cessation                     | 2 face-to-face assessments per calendar year  
  $0 per visit  
  $0 per prescription medication | $0 per visit  
  $0 per prescription medication |
<table>
<thead>
<tr>
<th>Benefit/Service</th>
<th>Notes/Limits</th>
<th>Non-Region 3</th>
<th>Region 3 Counties</th>
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<tbody>
<tr>
<td>Transplant Services</td>
<td></td>
<td>$0 per transplant service</td>
<td>$0 per transplant service</td>
</tr>
<tr>
<td>Transportation – Emergency Ambulance and Air Transportation</td>
<td>Basic life support and advanced life support ambulance services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Transportation – Non-Emergency Ambulance Stretcher Services</td>
<td>Covered when other means of transportation could endanger the member’s health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation – Non-Emergency Transportation</td>
<td>Not covered by WellCare – This service is covered by KY Medicaid Fee-for-Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Urgent illness or injury when the primary care office is closed or cannot be reached</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Vision (Members under 21)</td>
<td>1 exam per calendar year. Limit of 1 pair of eyeglasses per year, or a 2nd pair if 1st pair is broken or prescription changes.</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Vision (Members 21 and over)</td>
<td>1 eye exam per year</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Extra Benefits for Members**

WellCare offers extra benefits to members at no cost. These include:

- Free Over-the-Counter (OTC) Items – $120 per year ($10/month) per family for OTC items sent to the member’s home, like diapers, vitamins and almost 100 other items
- Prenatal Rewards Program – Free baby stroller when the member attends all of her doctor visits during and after pregnancy
- Free baby shower – The member may attend a shower in her community and get a gift basket and tips to keep her and her baby healthy
- Unlimited prescription drugs
- Free flu shots
- GED® exam – Members age 16 and older with no high school diploma can take the GED test for free
- Unlimited medically necessary prescriptions – All members age 19 and older have no limit on medically necessary prescription drugs (generic and brand)
• Free respite care – Short-term care that gives relief to caregivers of eligible Supplemental Security Income (SSI) members
• Free personal care and disease managers to offer members support for conditions like diabetes and asthma, etc.
• 24-Hour Nurse Advice Line – WellCare’s Nurse Advice Line is available to members at no cost. Members can call the line 24 hours per day, seven days per week.

For the most up-to-date information on Covered Services, please refer to Title 907 of the Kentucky Administrative Regulations available on the Web at http://www.lrc.ky.gov/kar/TITLE907.HTM.

Provider Services
WellCare’s Provider Services Department is comprised of two teams – Provider Relations and Provider Operations. The Provider Relations team is responsible for provider education, recruitment, contracting, new provider orientation, monitoring of quality and regulatory standards such as Healthcare Effectiveness Data and Information Set (HEDIS®) and investigation of member complaints. The Provider Operations team consists of Contract Operations, collection of credentialing and re-credentialing documents, and claims research and resolution.

WellCare offers an array of provider services which includes initial orientation and education, either one-on-one or in a group setting, for all providers. These sessions are hosted by WellCare’s Provider Relations representatives.

Provider Relations representatives are available to assist in many requests for providers. Providers may contact their local market offices for assistance. To request that a Provider Relations representative contact them, providers may call the Provider Services number located on the Quick Reference Guide.

Providers may contact the appropriate departments at WellCare by referring to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

Website Resources
WellCare’s website, https://kentucky.wellcare.com/, offers a variety of tools to assist providers and their staffs.

Available resources include:
• Provider Manual;
• Quick Reference Guide;
• Clinical Practice Guidelines;
• Clinical Coverage Guidelines;
• Forms and documents;
• Pharmacy and provider lookup (directories);
• Authorization lookup tool;
• Training materials and job aids;
• Newsletters;
Secure Provider Portal – Benefits of Registering
WellCare’s 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 login and password using their WellCare 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 copies of 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.
- **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 provider claims, eligibility inquiries and authorization requests.

How to Register

After registering for WellCare’s website, providers should retain login and password information for future reference.

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

Additional Resources
The Provider Resource Guide contains information about WellCare’s secure online Provider Portal, member eligibility, authorizations, filing paper and electronic claims, appeals and more. For direct access to WellCare’s Provider Services team for day-to-day administrative tasks, please see the WellCare Quick Access Guide to Provider Services. Both documents can be found on WellCare’s website at [https://kentucky.wellcare.com/provider/job_aids_and_resource_guides](https://kentucky.wellcare.com/provider/job_aids_and_resource_guides).
Another valuable resource is the *Quick Reference Guide*, which contains important addresses, phone/fax numbers and authorization requirements. Providers can find the *Quick Reference Guide* at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources).
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

This section is an overview of guidelines for which all participating WellCare Medicaid Managed Care providers are accountable. Please refer to the provider Agreement or contact a Provider Relations representative for clarification of any of the following.

Participating WellCare Medicaid providers must, in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973;
- Agree to cooperate with WellCare in its efforts to monitor compliance with its Medicaid contract(s) and/or Department rules and regulations, and assist WellCare in complying with corrective action plans necessary for WellCare to comply with such rules and regulations;
- Retain all agreements, books, documents, papers and medical records related to the provision of services to WellCare members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care 42 C.F.R. § 422.504(a)(3)(iii);
- Use physician extenders appropriately. Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs) should provide direct member care within the scope or practice established by the rules and regulations of the Commonwealth and WellCare guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and APRNs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician and extender titles (examples: M.D., D.O., APRN, PA) to members and to other health care professionals;
- Honor at all times any member’s 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 health care services;
- Cooperate with QI Activities;
- Maintain the confidentiality of member information and records;
- Allow WellCare to use provider performance data;
- Respond promptly to WellCare’s request(s) for medical records in order to comply with regulatory requirements and maintain the confidentiality of member information and records;
- Ensure that:
  - All employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement between the provider and WellCare;
To the extent the physician maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and

- The physician maintains written agreements with all contracted physicians or other health care practitioners and providers, which agreements contain similar provisions to the Agreement.

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;

- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the member or the requesting party at no charge, unless otherwise agreed;

- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen;

- Not discriminate in any manner between WellCare Medicaid members and non-WellCare Medicaid members;

- Ensure that the hours of operation offered to WellCare members is not fewer than those offered to commercial members;

- Not deny, limit or condition the furnishing of treatment to any WellCare Medicaid 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 health care;
  - 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 the member's behalf for the 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 who are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to WellCare-sponsored or community-based programs; and

- 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. WellCare is not financially responsible for non-covered benefits or for services rendered to
ineligible recipients. Certain covered benefits, such as non-emergency transportation, are administered outside of the managed care program.

Excluded services are defined as those services that members may obtain under the Kentucky Medicaid plan and for which WellCare is not financially responsible. These services may be paid for by the Department on a fee-for-service 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 Department. In the event the service(s) is (are) prohibited, neither WellCare nor the Department is financially responsible. For more information on prohibited services, refer to the Department’s website at http://chfs.ky.gov/dms/.

School-based services provided by schools are excluded from coverage by WellCare and are paid by the Department through fee-for-service Medicaid. Any service provided under a child’s Individualized Education Program (IEP) should not be duplicated. However, the Preventive Health Package pursuant to 907 KAR 1:360 is covered when supervised by appropriate medical personnel.

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

Provider Identifiers
All participating providers are required to have a unique Kentucky Medicaid provider number and a National Provider Identifier (NPI). For more information on NPI requirements, refer to Section 5: Claims. A current Medicaid provider number is an important Medicaid program integrity control. WellCare verifies current Kentucky Medicaid provider status by reference to data provided to it periodically by the Department. It is a provider’s responsibility to maintain a current Kentucky Medicaid provider number with the Department. WellCare may deny reimbursement for claims for Covered Services if it determines that the provider does not have a current Kentucky Medicaid provider number at the time it adjudicates the claim.

Living Will and Advance Directive
Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their lives. Living will and advance directive rights may differ between states. Kentucky providers should follow the applicable KRS Section 311.621 - 311.643. Providers must comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care hospices and health maintenance organizations (HMOs) specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d).

Each WellCare member (age 18 years or older and of sound mind), should receive information regarding living wills and advance directives. This allows members to designate another person to make a decision should they become mentally or physically unable to do so.
Information regarding living wills and advance directives should be made available in provider offices. Providers are also required to discuss living wills and advance directives with members during their first primary care visit. 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 (TIN) or Entity Affiliation (W-9 required);
- Group name or affiliation;
- Physical or billing address;
- Telephone and fax number;
- Panel changes; and/or
- Directory listing.

**Provider Termination**

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

- Any contracted provider must give at least 90 days prior written notice (180 days for a hospital) to WellCare before terminating his or her relationship with WellCare “without cause,” unless otherwise agreed to in writing. This ensures that adequate notice may be given to WellCare members regarding the provider’s participation status with WellCare. Please refer to the provider Agreement for 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; and
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.

Please refer to Section 6: Credentialing of this Manual for specific guidelines regarding rights to appeal plan termination (if any).

WellCare 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 Kentucky Medicaid program requirements and/or regulations and statutes.

**Out-of-Area Member Transfers**

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

Individuals with Special Health Care Needs (ISHCN) include members with the following conditions:

- Mental retardation or related conditions;
- Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes;
- Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and
- Related populations eligible for Supplemental Security Income (SSI).

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

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

For more information regarding utilization management for ISHCN, refer to Section 4: Utilization Management, Care Management and Disease Management.

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.

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. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.
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 per day, seven days per week. To ensure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
- An answering system with the option to page the physician for a return call within a maximum of 30 minutes; or
- 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 access standards.

**Responsibilities of Primary Care Providers**

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

- 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 EPSDT services for members under the age of 21;
- Coordinate, monitor and supervise the delivery of primary care services to each member;
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants and Children (WIC) Program for nutritional assistance;
- Screen all newborn members for those disorders specific in the Commonwealth’s metabolic screen;
- Assure members are aware of the availability of public transportation where available;
• Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
• Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® 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 Provider Services for assistance. Refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources; and
• Comply with and participate in corrective action and performance improvement plan(s).

Early and Periodic Screening, Diagnosis and Treatment
Any provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide EPSDT screening services are responsible for:
• Providing all needed initial, periodic and interperiodic EPSDT health assessments, diagnosis and treatment to all eligible members in accordance with Kentucky Medicaid administrative regulation 907 KAR 11:034 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 18-years-old and younger;
• Addressing unresolved problems, referrals and results from diagnostic tests, including results from previous EPSDT visits;
• Requesting a 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 Kentucky Medicaid Program;
• Monitoring, tracking and following up with members:
  o Who have not had a health assessment screening; and
  o 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; and
• Assisting members with transition to other appropriate care for children who age out of EPSDT services.
Except as otherwise noted by WellCare or in 907 KAR Chapter 1 or 3, an EPSDT diagnosis or treatment or an EPSDT special service which is not otherwise covered by the Kentucky Medicaid Program shall be covered subject to prior authorization if the requirements of subsections (1) and (2) of Section 9 of 907 KAR 11:034 are met. Requests for services will be reviewed to determine medical necessity without regard to whether the screen was performed by a Kentucky Medicaid provider or a non-Medicaid provider.

Providers will be sent a monthly membership list which specifies the health assessment-eligible children who have not had an encounter within 120 days of joining WellCare or who are not in compliance with the EPSDT program.

The provider’s compliance with member monitoring, tracking and follow-up will be assessed through random medical record review audits conducted by the WellCare Quality Improvement Department. Corrective action plans will be required for providers who are below 80 percent compliance with all elements of the review.

For more information regarding the Kentucky Medicaid EPSDT periodicity schedule and/or the Kentucky Medicaid administrative regulation 907 KAR 11:034, refer to the Department’s website at [http://chfs.ky.gov/dms/](http://chfs.ky.gov/dms/). For more information on the periodicity schedule based on the AAP guidelines, refer to the AAP website at [http://www2.aap.org/immunization/IZSchedule.html](http://www2.aap.org/immunization/IZSchedule.html).

**Primary Care Offices**

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

- Support of the Provider Relations, Member Services, Health Services and Marketing and Sales Departments;
- The tools and resources available on WellCare’s website at [https://kentucky.wellcare.com/provider/default](https://kentucky.wellcare.com/provider/default); and
- Information on WellCare network providers for the purposes of referral management and discharge planning.

**Closing of Provider Panel**

When requesting closure of a panel to new and/or transferring WellCare 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 WellCare members who were provided services before the closing of the panel; and
- 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 WellCare members, providers should make arrangements with another WellCare-contracted, Medicaid-participating and credentialed provider to deliver services on their behalf, unless there is an emergency.
Covering providers should be credentialed by WellCare, and are required to sign an agreement accepting the negotiated rate and agreeing not to balance bill WellCare members. For additional information, please refer to Section 6: Credentialing.

In non-emergency cases, should a provider have a covering physician/provider who is not contracted and credentialed with WellCare, contact WellCare for approval. For contact information, refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

**Termination of a Member**

A WellCare provider may not seek or request to terminate his or her relationship with a member, or transfer a member to another provider, based upon the member’s medical condition, amount or variety of care required or the cost of Covered Services required by WellCare's member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. In the event that a participating provider desires to terminate his or her relationship with a WellCare member, the provider should submit adequate documentation to support that, although he or she has attempted to maintain a satisfactory provider and member relationship, the member’s non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the WellCare member until such time that written notification is received from WellCare stating that the member has been transferred from the provider’s practice, and such transfer has occurred.

The provider should complete a PCP Request for Transfer of Member form, attach supporting documentation and fax the form to WellCare’s Provider Services Department. A copy of the form is available on WellCare’s website at https://kentucky.wellcare.com/provider/forms_and_documents.

**Domestic Violence and Substance Abuse Screening**

PCPs should identify indicators of substance abuse or domestic violence. Coming Soon - Sample screening tools for domestic violence and substance abuse will be located on WellCare’s website.

**Smoking Cessation**

PCPs should direct members who wish to quit smoking to call WellCare’s Customer Service and ask to speak to the Care Management Department. A Care Manager will educate the member on national and community resources that offer assistance, as well as smoking cessation options available to the member through WellCare.

**Adult Health Screening**

An adult health screening should be performed to assess the health status of all WellCare Medicaid members, as applicable. The adult member should receive an appropriate assessment and intervention as indicated or upon request.
Hospital/Facility Responsibilities
Coverage is provided for eligible members for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Care must be rendered under the direction of a doctor or by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority. The provider must be qualified to participate under Title XIX (Medicaid) of the Social Security Act.

In compliance with Section 1902 (a) (57) of the Social Security Act, hospitals must:
- Provide written information to patients regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- Provide written information to individuals regarding the institution’s or program’s written policies respecting the implementation of the right to formulate advance directives;
- Document in the patient’s medical record whether or not an advance directive has been executed;
- Comply with all requirements of state law respecting advance directives;
- Provide (individually or with others) education for staff and the community on issues concerning advance directives; and
- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

WellCare defines an inpatient as a patient who has been admitted to a participating hospital on the recommendation of a licensed doctor and is receiving room, board and professional services in the hospital on a continuous 24 hours per day basis. Transfers between units within the hospital are not considered new admissions, unless it is a transfer from a medical unit to a psychiatric unit. Refer to Section 4: Utilization Management, Care Management and Disease Management for more information.

WellCare defines an outpatient as a patient who is receiving professional services at a participating hospital, but who is not provided room and board and professional services on a continuous 24 hours per day basis. Observation services are also considered outpatient. Observation services usually do not exceed 24 hours.

However, some patients may require 72 hours of outpatient observation services. Refer to Section 4: Utilization Management, Care Management and Disease Management for more information.

Free-standing (satellite) clinics, which are not operated as part of a hospital, are considered doctors’ offices by WellCare. Services provided in these clinics and other away-from-hospital settings are not covered as hospital services.

Hospital-based clinics, which are operated as part of a hospital, are considered outpatient hospital-based facilities by WellCare. As such, these facilities must follow authorization rules for hospital-based services. Refer to Section 4: Utilization Management, Care Management and Disease Management for more information.
Level of care determinations will be based on InterQual™ criteria and Medical Director review.

**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 and to see that members in need of linguistic services receive adequate communication support. 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 that may have cultural, linguistic or disability-related barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on the member’s race, ethnicity, condition of disability and/or primary language spoken;
- Ensure that resources are available to overcome the language and communication barriers that exist in the member population;
- Make certain that providers care for and recognize the culturally diverse needs of the population;
- Teach staff to value the diversity of both their coworkers inside the organization and the population served, and to behave accordingly; and
- Provide cultural competency and disability training to all staff members and ensure training is provided both orally and in written format.

**Cultural competence in health care** describes a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. Health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

**Culturally and linguistically appropriate services (CLAS):** The collective set of culturally and linguistically appropriate services (CLAS) mandates guidelines and recommendations intended to inform, guide and facilitate required and recommended practices related to culturally and linguistically appropriate health services. The U.S. Department of Health and Human Services, Office of Minority Health, has issued national CLAS standards. WellCare is committed to a continuous effort to perform according to those standards.

The components of WellCare’s Cultural Competency program include:

- WellCare analyzes data on the populations in each region it serves quarterly and as needed for the purpose of learning their cultural and linguistic needs as well as any health disparities they may suffer. Such analyses are performed at the time 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:
  - State-supplied data for Medicaid and CHIP populations;
• Demographic data available from the U.S. Census and any special studies done locally;
• Claims and encounter data to identify the health care needs of the population by identifying the diagnostic categories that are the most prevalent;
• Member requests for assistance, plus complaints and grievances, to identify areas of opportunity to improve service to members from a cultural and linguistic angle; and
• 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’s success requires linking with other groups having the same goals.
  o WellCare reaches out to community-based organizations that support racial and ethnic minorities and disabled people to ensure that the community’s existing resources for members who have special needs are utilized to their full potential. The goal is to coordinate the deployment of both community and health plan resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.
  o WellCare will develop and maintain grassroots sponsorships that will enhance WellCare’s effort to reach low-income communities and provide opportunity for building meaningful relationships that benefit all members of the communities. These sponsorships will be coordinated with providers, community health fairs and public events.

• Management Accountability for Cultural Competency – The Quality Improvement Committee maintains ultimate responsibility for the activities carried out by the health plan related to cultural competency. The committee oversees the day-to-day operations of the quality program in the health plan including the Cultural Competency Program and improvement activities undertaken by the individual WellCare plans.
  o WellCare's Director of Quality Improvement is the principal executive in charge of the company's efforts to meet its internal cultural competency objectives and any externally set rules and guidelines on the subject. The Director of Quality Improvement collaborates with the heads of all of WellCare’s functional units in making certain that the Cultural Competency Program plan is fully and properly executed.
  o The Senior Management team, comprised of the unit leaders of all major functional departments of WellCare Health Plans and the heads of the state operations, is responsible for ensuring that culturally sensitive training occurs in their respective areas.

• Diversity and Language Abilities of WellCare – WellCare recruits diverse, talented staff members to work in all levels of the organization. WellCare does not discriminate with regard to race, religion or ethnic background when hiring staff.
  o WellCare ensures that bilingual staff members are hired for functional units that have direct contact with members to meet the needs identified. Today, one-third of WellCare’s Customer Service representatives are
bilingual. 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. For example, in Georgia, approximately two-thirds of the Hispanic population is of Mexican origin. In Florida and New York City, the Puerto Rican population is predominant.

- Where WellCare enrolls significant numbers of members who speak languages other than English or Spanish, WellCare seeks to recruit staff 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 and this information is made available in the Provider Directory so that members can choose a provider that speaks their primary language.
  - Providers are recruited to ensure a diverse selection of providers to care for the population served.
- Linguistic Services
  - Providers will identify members 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 will be provided by vendors with such expertise and are coordinated by WellCare's Customer Service Department.
  - Written materials are available for members in large print format and certain non-English languages prevalent in WellCare’s service areas.
- Electronic Media
  - Telephone system adaptations – Members have access to the TTY line for hearing-impaired services. WellCare’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.
- Linkage to Community
  - WellCare is dedicated to partnering with community organizations to promote cultural understanding and to meet the needs of the diverse population. Wherever possible, WellCare will pursue linkages with national, state and local organizations dedicated to advancing both the broad interests and the health interests of groups having needs for culturally-based supports.
- Member/Patient Education
  - The multicultural basis of WellCare’s patient education program is drawn from the Healthy People 2020 initiative. Healthy People 2020 is a “national health promotion and disease prevention initiative that brings together government agencies, nonprofit, voluntary, and professional organizations, businesses, communities and individuals to improve the
health of all Americans, eliminate disparities in health, and improve years and quality of healthy life.” (https://www.healthypeople.gov/2020/About-Healthy-People)

- Given the nature of the population WellCare serves, from the 2020 list of conditions with disparate impacts on racial and ethnic minorities, WellCare has chosen diabetes, asthma and cardiovascular disease as the areas its member health education will focus on.
- Upon enrollment, members receive a welcome packet that includes a Member Handbook, which outlines WellCare’s Disease Management Program.

**Member Rights**
- WellCare adopts and acts on the basis of the Medicaid member rights and responsibilities as approved by each state’s Medicaid agency. All associates, including Customer Service representatives, are expected to treat members in a manner that respects their rights and the expectations of their responsibilities.

**Provider Education**
- WellCare’s Cultural Competency Program provides a Cultural Competency Checklist to assess the provider office’s Cultural Competency.

**Provider Performance Monitoring**
- In the event that members file complaints or grievances with WellCare concerning a provider that behaves in a manner inconsistent with standards for culturally and linguistically appropriate services, WellCare will investigate the matter with the same degree of concern applied to any other complaint or grievance. Offending providers will be expected to take corrective measures, and WellCare will follow-up to make certain that such action indeed was taken.
- If WellCare observes patterns in complaint and grievance information that suggest there are systemic deficiencies in providers’ conformance to cultural competency aims, WellCare will investigate the root causes and define broad performance improvement projects to eliminate the weakness.

**Ongoing Self-Assessment**
- WellCare will continually assess the cultural competency of the company, both nationally and at the level of each health plan unit, to ensure that WellCare is meeting the diverse needs of its members, providers and staff. A component of the self-assessment will be to utilize focus groups of members, providers and staff to explore the needs of all WellCare constituent groups and to listen to suggestions for improving its Cultural Competency Program.
- Annually, the Cultural Competency Program will be reviewed, revised and presented to the Quality Improvement Committee to ensure compliance with the program objectives.

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

For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on WellCare’s website at
Cultural Competency Survey
Providers may access the Cultural Competency Survey on WellCare’s website at https://kentucky.wellcare.com/provider/provider_training_and_education.

Member Administrative Guidelines

Overview
WellCare will make information available to members on the role of the PCP, how to obtain care and 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 will be sent a Member Handbook within five calendar days of receiving the notice of enrollment from WellCare. WellCare will mail all enrolled members a Member Handbook annually thereafter.

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

Upon enrollment in WellCare, members are provided with the following:
- Terms and conditions of enrollment;
- Description of Covered Services in network and out of network (if applicable);
- Information about PCPs, such as location, telephone number and office hours;
- Information regarding out-of-network emergency services;
- Grievance and appeal procedures; and
- Brochures describing certain benefits not traditionally covered by Medicaid and other value-added items or services, if applicable.

Member Identification Cards
Member identification cards are intended to identify WellCare members, the type of plan they have and to facilitate their interactions with health care 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, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

Eligibility Verification
A member’s eligibility status can change at any time. Therefore, all providers should consider requesting and copying a member’s identification card, along with additional proof of identification such as a photo ID, and filing them in the medical record.
Providers may do one of the following to verify eligibility:

- Access the WellCare website at www.kentucky.wellcare.com. Providers must be registered on WellCare’s site and log in;
- Access WellCare’s Interactive Voice Response (IVR) system. Providers will need their provider ID number to access member eligibility;
- Access the Commonwealth website at http://www.chfs.ky.gov/dms/kyhealth.htm; and/or
- Contact the Provider Services Department.

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

Eligibility Requirements

In the event that a member changes managed care organizations and the provider delivers services to an individual who is not a member of WellCare, but is a member of another managed care organization, WellCare is entitled to recoup any payment made to the provider. The managed care organization that the member is eligible for is responsible for payment of services delivered during the period of adjusted eligibility.

Member Rights and Responsibilities

WellCare members, both adults and children, have specific rights and responsibilities. These are included in the Member Handbook. WellCare members have the right:

- To get information about WellCare, its services and its doctors and providers;
- To get information about their rights and responsibilities;
- To know the names and titles of doctors and other health providers caring for them;
- To be treated with respect and dignity, confidentiality and nondiscrimination;
- To have their privacy protected;
- To have a reasonable opportunity to choose a PCP and to change to another provider in a reasonable manner;
- To agree to or refuse treatment and active participation in decision choices;
- To decide with their doctor what care they receive;
- To talk openly about care they need for their health, no matter the cost or benefit coverage, and the choices and risks involved. The information must be given in a way they understand;
- To timely access to care that does not have any communication or physical access barriers;
- To have the risks, benefits and side effects of medications and other treatments explained to them;
- To know about their health care needs after they get out of the hospital or leave the doctor’s office;
- To refuse care, as long as they agree to be responsible for their decision;
- To refuse to take part in any medical research;
- To voice complaints or appeals about WellCare or the care it provides. Also, to know that if they do, it will not change how they are treated;
To not be responsible for WellCare’s debts in the event of insolvency and to not be held liable for payments of Covered Services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the member would owe if the contractor provided the services directly;

To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

To ask for and get a copy of their medical records from providers in accordance with applicable federal and state laws. Also, to ask that the records be changed/corrected if needed. Requests must be received in writing from the member or member’s representative. The records will be provided at no cost to the member, and they will be sent within 14 days of receipt of the request;

To timely referral and access to medically indicated specialty care;

To have their records kept private;

To make their health care wishes known through advance directives;

To prepare advance medical directives pursuant to KRS311.621.to KRS311.643;

To have a say in WellCare’s member rights and responsibilities policy;

To voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and receive a hearing from WellCare and/or the Department for Medicaid Services;

To appeal medical or administrative decisions by using WellCare’s or the Commonwealth’s grievance process;

To exercise these rights regardless of sex, age, race, ethnicity, income, education or religion;

To have all WellCare staff observe their rights;

To have all the above rights apply to the person legally able to make decisions about their health care;

To be furnished services in accordance with 42 CFR 438.206 through 438.210, which includes accessibility, authorization standards, availability, coverage, coverage outside of network and the right to a second opinion; and

To be responsible for cost sharing only as specified under Covered Services co-payments and to be responsible for cost sharing only as specified in the contract.

WellCare members have the responsibility:

To become informed about member rights;

To give information that WellCare and its providers need to deliver care;

To abide by WellCare’s and the Department’s Policies and Procedures;

To become informed about service and treatment options;

To actively participate in personal health care decisions and practice healthy lifestyles;

To report suspected fraud and abuse;

To follow plans and instructions for care that they have agreed to with their provider;

To understand their health problems;

To help set treatment goals that they agree to with their provider;

To read the Member Handbook to understand how the plan works;

To carry their member ID cards at all times;
• To carry their Medicaid cards at all times;
• To show their ID cards to each provider;
• To schedule appointments for all non-emergency care through their provider;
• To get a referral from their provider for specialty care;
• To cooperate with the people who provide their health care;
• To be on time for appointments;
• To tell the doctor’s office if they need to cancel or change an appointment;
• To respect the rights of all providers;
• To respect the property of all providers;
• To respect the rights of other patients;
• To not be disruptive in the doctor’s office;
• To know the medicines they take, what they are for and how to take them the right way;
• To make sure their providers have copies of all previous medical records; and
• To let WellCare know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care.

Assignment of Primary Care Provider
All Kentucky Medicaid members enrolled in a WellCare Medicaid plan, except dual-eligible members, children in foster care or state guardianship and those with adult guardianship, must choose a PCP or they will be assigned to a PCP within WellCare’s network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member’s health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or non-emergency hospital services.

If a provider’s name is not identified as the Primary Care Provider on the member’s card, the member may see that provider as long as the provider is participating in network.

Changing Primary Care Providers
Members may change their PCP selection at any time by calling Customer Service. Providers can also assist members in changing their designated PCP while the member is in the provider’s office by completing the PCP Change Request Form located on WellCare’s website at https://kentucky.wellcare.com/provider/forms_and_documents.

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

Hearing-Impaired, Interpreter and Sign Language Services
Hearing-impaired, interpreter and sign language services are available to WellCare members through WellCare’s Customer Service. PCPs should coordinate these services for WellCare members and contact Customer Service if assistance is needed. Please refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources for the Customer Service telephone numbers.
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 health care and services. Strategies are identified and activities implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas including:

- Quantitative and qualitative improvement in member outcomes;
- Confidentiality;
- Coordination and continuity of care with seamless transitions across health care settings/services;
- Cultural Competency;
- Quality of care/service;
- Credentialing;
- Preventive health;
- Complaints/grievances;
- Network adequacy;
- Appropriate service utilization;
- Disease and Care Management;
- Behavioral health services;
- Appeals and grievances;
- Member and provider satisfaction;
- Components of operational service, and
- Regulatory/federal/state/accreditation requirements.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS® measures and/or medical record audits. The Quality Improvement Committee is delegated by WellCare’s board of directors to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas needing improvement are identified.

The goals of the QI Program are to:

- Develop and maintain a well-integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate and evaluates the result of actions taken to improve quality-of-care outcomes and service levels;
- Ensure availability and access to qualified and competent providers;
- Establish and maintain safeguards for member privacy, including confidentiality of member health information;
- Engage members in managing, maintaining or improving their current states of health through fostering the development of a primary care provider-patient relationship and participation in care programs;
- Provide a forum for members, providers, various health care associations and community agencies to provide suggestions regarding the implementation of the QI Program; and
- Ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.

**Provider Participation in the Quality Improvement Program**

Network providers are contractually required to cooperate with quality improvement activities, which include providing member records for assessing quality of care. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule at 45 CFR 164.506 permits a covered entity (provider) to use and disclose Protected Health Information (PHI) to health plans without member authorization for treatment, payment and health care operations activities. Health care operations include, but are not limited to, the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, care management and care coordination.

Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, EPSDT assessments and feedback/input via satisfaction surveys, grievances and calls to Provider Services. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Information regarding the QI Program is available upon request and includes a description of the QI Program and a report assessing the progress in meeting goals. WellCare evaluates the effectiveness of the QI Program on an annual basis. An annual report is published which reviews completed and continuing QI activities that address the quality of clinical care and service, trends measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions which are recommended or in progress, and identifies any modifications to the QI Program. This report is available as a written document.

**Member Satisfaction**

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

**Early and Periodic Screening, Diagnosis and Treatment Periodicity Schedule**

The preventive pediatric health care guidelines for children are located on WellCare’s corporate website at [www.wellcare.com/Provider/CPGs](http://www.wellcare.com/Provider/CPGs).

A member should have an initial health check screening in the following situations:
- Within 90 days of joining WellCare or upon change to a new PCP if prior medical records do not indicate current compliance with the periodicity schedule; and
- Within 24 hours of birth for newborns.
The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening should be performed at age 5.

The medical record must contain documentation of a comprehensive health history during the initial visit in addition to a complete unclothsed physical examination to determine if the child's development is within the normal range for the child's age and health history.

Each provider office is required to have the following equipment to provide a complete health check:

- Weight scale for infants;
- Weight scale for children and adolescents;
- Measuring board or device for measuring length or height in the recumbent position for infants and children up to age 2;
- Measuring board or device for measuring height in the vertical position for children who are 2-years-old or older;
- Blood pressure apparatus with infant, child and adult cuffs;
- Screening audiometer;
- Centrifuge or other device for measuring hematocrit or hemoglobin;
- Eye charts appropriate to children by age;
- Developmental and behavioral screening tools; and
- Ophthalmoscope and otoscope.

Additional points of emphasis regarding EPSDT screens include the following:

- **Visit Requirements** – An interval health history, age appropriate assessment of physical and mental health development, assessment of nutrition, complete/unclothsed physical exam, age appropriate health education/anticipatory guidance and growth chart are completed at each visit.

- **Immunizations** are administered at required age parameters and intervals with dates documented. If the immunizations are not up-to-date according to age and health history, the provider should document why immunizations were not given at the time of the EPSDT screen. For the immunization schedule, refer to the preventive pediatric health care guidelines for children located on WellCare’s corporate website at [http://www.wellcare.com/provider/CPGs](http://www.wellcare.com/provider/CPGs). Note that certain immunizations may not be covered in the context of covered benefits.

- **PCP Responsibilities** – A PCP is responsible to perform all required components of an EPSDT health screen, as per the AAP and ACIP periodicity schedules, and document appropriately in the member’s medical record. If a PCP chooses not to provide the immunization component of the screen, she or he has accountability to refer the member to another network provider (such as a health department entity) who can provide this service in a timely manner. WellCare will expect the PCP to follow-up with the referred provider to obtain documentation regarding the provision of the immunization(s) in order to maintain an accurate and complete medical record. WellCare will monitor for compliance to these requirements by reviewing immunization rates by the PCP. In the event the immunization rate of the PCP is less than the network average, WellCare will assess for practice access and availability by:
  - Conducting an audit to verify compliance with access and availability;
- Requiring adoption of a corrective action plan (CAP) if access and availability standards are not met; and
- Performing a focused medical record review. Based on negative findings, a CAP will be requested.
  - If compliance to the CAP is not demonstrated, WellCare will assess for a fee reduction; and
  - If lack of compliance continues, WellCare will petition for removal from network participation.

- **Lead Exposure Assessment** is done at the 6-month through 6-year age visits. Lead blood level for children with low-risk history is done at the 12-month and 2-year age visit. Lead blood levels in children with a high-risk history are done immediately. Any risk identified through lead risk assessment should be both documented in the medical record and addressed.

- **Annual Tuberculosis (TB) Skin Testing** is done if the member is in a high-risk category. Only those children locally identified at high-risk for TB disease should be tested. Results of TB risk assessment and testing as needed should be documented in the child’s medical record.

- **Developmental Delay** is to be assessed by use of a formalized tool at 9 months and 18 months and at 2 years and 3 years.

- **120-Day Non-Compliant Report** is a report that WellCare will send providers. It includes a monthly membership list of EPSDT-eligible children who have not had a screen within 120 days of enrolling in WellCare or who are not in compliance with the EPSDT periodicity schedule. The PCP shall contact these members’ parents or guardians to schedule an appointment. WellCare will also send letters to the parents and guardians of EPSDT-eligible children to remind them of preventive services needed based on the child’s age.

- **Establish and maintain a tracking system** to monitor acceptance and refusal of EPSDT service, whether eligible Members are receiving the recommended health assessments, and all necessary diagnosis and treatment, including EPSDT Special Services, when needed.

**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. Providers are also measured annually for their compliance with Clinical Practice Guidelines. Areas identified for improvement are tracked and corrective actions are taken as indicated. The effectiveness of corrective actions is monitored until the problem is resolved. Approval of the Clinical Practice Guidelines occurs through the Quality Improvement Committee. Clinical Practice Guidelines, including preventative health guidelines, are on WellCare’s website at [http://www.wellcare.com/provider/CPGs](http://www.wellcare.com/provider/CPGs).
Healthcare Effectiveness Data and Information Set
HEDIS® is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. The tool comprises 71 measures across eight domains of care, including:
- Effectiveness of care;
- Access and availability of care;
- Satisfaction with the care experience;
- Use of services;
- Cost of care;
- Health plan descriptive information;
- Health plan stability; and
- Informal health care choices.

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

Medical Records
Medical records should be comprehensive and reflect all aspects of care for each member. Records are to be maintained in a timely, legible, current, detailed and organized manner in order to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to:
- Medical charts;
- Prescription files;
- Hospital records;
- Provider specialist reports;
- Consultants’ and other health care professionals’ findings;
- Appointment records; and
- Other documentation sufficient to disclose the quantity, quality appropriateness and timeliness of service provided.

Medical records must be signed and dated by the provider of service.

The member’s medical record is the property of the provider who generates the record. However, each member or her or his representative is entitled to one free copy of his or her medical record. Additional copies shall be made available to members at cost. WellCare follows state and federal laws regarding the retention of records remaining under the care, custody and control of the physician or health care provider.

Each provider is required to maintain a primary medical record for each member, which contains sufficient medical information from all providers involved in the member’s care to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:
- Member identification information on each page;
• Personal/biographical data, including:
  o Date of birth;
  o Age;
  o Gender;
  o Marital status;
  o Race or ethnicity;
  o Mailing address;
  o Home and work addresses and telephone numbers;
  o Employer;
  o School;
  o Emergency contact name and telephone numbers (if no phone, contact name and address);
  o Consent forms; and
  o Identification of language spoken and guardianship information.
• Date of data entry and date of encounter;
• Provider identification by name;
• Allergies and adverse reactions 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 (i.e., documentation of chicken pox);
• Identification of current problems;
• Consultation, laboratory and radiology reports shall be filed in the medical record and must have documentation indicating review (ordering provider’s initials);
• Documentation of immunizations pursuant to 902 KAR 2:060;
• Identification and history of nicotine and alcohol use or substance abuse;
• Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;
• Follow-up visits provided secondary to reports of emergency room care;
• Hospital discharge summaries;
• Advanced directives for adults;
• All written denials of service and the reason for the denial; and
• Record legibility to at least a peer of the writer. 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:
• History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;
• Unresolved problems, referrals and results from diagnostic tests, including results and/or status of preventive screening services (EPSDT), are addressed from previous visits; and
• Plan of treatment including:
  o Medication history, medications prescribed, including the strength, amount, directions for use and refills;
  o Therapies and other prescribed regimen; and
Follow-up plans, including consultation and referrals and directions, including time to return.

PCPs and identified high-volume specialists are measured at least once every three years for their compliance with medical record documentation standards. Identified areas for improvement are tracked, and corrective actions are taken as indicated. Effectiveness of corrective actions is monitored until problem resolution occurs.

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 laws. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

For more information on the confidentiality of member information and release of records, refer to Section 8: Compliance.

Patient Safety to Include Quality of Care and Quality of Service

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

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

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

Preventive guidelines address prevention and/or early detection interventions and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices and the member’s needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from participating providers and the Quality Improvement Committee. Activities include distribution of information, encouragement to utilize screening tools and ongoing monitoring and measuring of outcomes. While WellCare can and does implement activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.
Web Resources
WellCare periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare’s website frequently for the latest news and updated documents at https://kentucky.wellcare.com/provider/quality.
Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)

Utilization Management

For purposes of this Utilization Management section, terms and definitions may be contained within this section, in Section 12: Definitions and Abbreviations, 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 health care 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 health care 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 health care services;
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing coordination and minimizing barriers in the delivery of behavioral and medical health care services.

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 health care and services based on WellCare 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, and financial incentives, if any, do not encourage or promote underutilization.

Medically Necessary Services

The determination of whether a covered benefit or service is medically necessary shall:
- Be based on an individualized assessment of the recipient’s medical needs; and
- Comply with the requirements established in this paragraph. To be medically necessary or a medical necessity, a covered benefit shall be:
  - Reasonable and required to identify, diagnose, treat, correct, cure, palliate or prevent a disease, illness, injury, disability or other medical condition, including pregnancy;
  - Appropriate in terms of the service, amount, scope and duration based on generally-accepted standards of good medical practice;
Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver or the health care provider, or for cosmetic reasons;

- Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;

- Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard;

- Provided in accordance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements for individuals under 21 years of age; and

- Provided in accordance with 42 C.F.R. 440.230.

**Criteria for Utilization Management Decisions**

WellCare's UM Program uses nationally recognized review criteria based on sound scientific medical evidence. Providers with an unrestricted license in the Commonwealth with professional knowledge and/or clinical expertise in the related health care specialty actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

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 Medicaid Contract;
- State Provider Handbooks, as appropriate;
- Federal and state statutes and regulations;
- Medicaid and Medicare guidelines; and
- Hayes Health Technology Assessment.

The nurse 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 providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by calling the Provider Services Department listed on the Quick Reference Guide on WellCare’s website at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources). Providers may advise and comment on the development and adoption of clinical criteria through their provider representative who can provide contact information for the Chair of the Medical Policy Committee or another WellCare Medical Director.

**Utilization Management Process**

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

- Notifications;
Referrals; Prior authorizations; Concurrent review; and/or Retrospective review.

Decision and notification time frames are determined by 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 https://kentucky.wellcare.com/Provider/forms_and_documents.

After-Hours Utilization Management
WellCare provides authorization of inpatient admissions 24 hours per day, seven days per week. Providers requesting after-hours authorization for inpatient admission should refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources to contact an after-hours nurse. Discharge planning needs that may occur after normal business hours will be handled by WellCare's after-hours nurse.

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 – Notification of prenatal services enables WellCare to identify pregnant members for inclusion into the Prenatal Program and/or WellCare’s High-Risk Pregnancy Program. Obstetrical providers are required to notify WellCare of pregnancies via fax using the Prenatal Notification Form within 30 days of the initial visit. This process will also expedite case management and claims reimbursement; and
- Inpatient Admission – Notification of a member’s admission to a hospital allows 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.

Referrals
A referral is a request by a PCP for a member to be evaluated and/or treated by a specialty provider. WellCare does not require authorization as a condition of payment for specialist consultations provided by WellCare-contracted providers. WellCare does not need to be notified when members are referred in in-network providers. Please see the Prior Authorization section below if the member is being referred to an out-of-network provider. 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. A searchable Authorization Lookup Tool is available online at https://kentucky.wellcare.com/provider/resources.

WellCare does not require providers to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs or ethical principles in accordance with 42 CFR 438.102. If a provider declines to perform a service because of ethical
reasons, the member should be referred to another provider licensed, certified or accredited to provide care for the individual service, or be assigned to another PCP licensed, certified or accredited to provide care appropriate to the member's medical condition. WellCare does not prohibit or restrict a provider from advising a member about his or her health status, medical care or treatment, regardless of whether benefits for such care are Covered Services, if the provider is acting within the lawful scope of practice.

**Prior Authorization**

Prior authorization is the process of obtaining approval in advance of rendering a service. Prior authorization may or may not require a medical record review. An authorization is the approval necessary for payment to be granted for Covered Services and is provided only after WellCare agrees the treatment is medically necessary and a covered benefit. Prior authorization allows for efficient use of covered health care services and ensures that members receive the most appropriate level of care at 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; and/or
- Care and disease management considerations.

Prior authorization is **required** for elective or non-emergency services as designated by WellCare. Guidelines for prior authorization requirements by service type may be found on the *Quick Reference Guide* on WellCare’s website at [https://kentucky.wellcare.com/provider/forms_and_documents](https://kentucky.wellcare.com/provider/forms_and_documents). Providers can also use the searchable Authorization Lookup Tool at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources).

Some prior authorization guidelines to note are:

- The prior authorization request should include the diagnosis to be treated and the *Physician’s Current Procedural Terminology, 4th Edition* (CPT-4) 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, total number of visits requested and the expected duration of care.

The attending physician or designee is responsible for obtaining the prior authorization of the elective or non-urgent admission.

There is no limit on the number of days Medicaid allows for medically necessary inpatient hospital care. If a member is readmitted to the hospital for the same or related problem within 14 days of discharge, it is considered the same admission. All admissions are subject to medical justification, and WellCare may request
documentation to substantiate medical necessity and appropriateness of setting. Documentation must be provided upon request in pre-payment or post-payment review. Failure to show appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

If a hospital determines that an outpatient hospital setting would have met the medical needs of a member after the services were provided in an inpatient setting, the services may be billed to WellCare as outpatient if the claim is received within 180 days of the ending date of the service month. If the claim is received more than 180 days after the ending date, the services are not covered.

To substantiate the determination, a physician’s order must document the member’s status at the time of admission and any changes in the member’s status.

**Authorization Request Forms**

WellCare requests that providers use WellCare’s standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to provider requests, including:

- **Inpatient Authorization Request Form** is used to request authorization for services such as planned elective/non-urgent inpatient observation, inpatient skilled nursing facility and rehabilitation admissions.
- **Outpatient Authorization Request Form** is used to request authorization for services such as select outpatient hospital procedures, out-of-network services and transition of care services.
- **DME Services Authorization Request Form** is used to request authorization for items such as motorized wheelchairs, insulin pumps and Dynasplint® Systems.
- **Skilled Therapy Services Authorization Request Form** is used to request authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services.
- **Home Health Authorization Request Form** is used to request authorization for services such as skilled nursing, home health aide and skilled therapy visits that are rendered in a home setting.

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; and
- Contain a clinical summary or have supporting clinical information attached.

Incomplete information will result in calls and/or faxes to the ordering provider for the missing information and could result in a delay for the member. All forms are located on WellCare’s website at [https://kentucky.wellcare.com/provider/forms_and_documents](https://kentucky.wellcare.com/provider/forms_and_documents). All forms should be submitted via fax to the number listed on the form.

**Procedures for Obtaining Prior Authorization for All Medical Services Except Dental Services and Transplants**

The attending physician or hospital staff is responsible for obtaining prior authorization from WellCare and for providing the prior authorization number to each WellCare provider associated with the case; i.e., assistant physician and hospital, etc. Failure to obtain prior authorization will result in denial of payment.
Requests for prior authorization should be submitted at least 10 business days prior to the planned admission or procedure. Once a procedure is approved, the approval is valid for 90 days from the date of issuance.

In cases when prior authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the member requires an additional or different procedure, the procedure will be considered an urgent procedure. The hospital's request for an update of the prior authorization will be considered timely if received within one business day of the date of the procedure.

When prior authorization has been obtained for an outpatient procedure, and after the procedure has been performed it is determined that the member requires inpatient services, the admission should be considered an emergency. The hospital should notify WellCare of the admission within 24 hours, and the request for a clinical update will be considered timely if received within one business day of the beginning date of the episode of care.

Hospital requests for updates of authorization and retroactive authorizations of inpatient admissions following a procedure will be denied if it is determined that the procedure clearly required an inpatient level of care that should have been anticipated.

When it is determined that a member with outpatient observation status requires inpatient services, the request for authorization must be received within one business day of the beginning of the episode of care.

**Procedures for Obtaining Prior Authorization for Dental Services**

Prior authorization is required for any dental service requiring inpatient or outpatient hospitalization. It is the responsibility of the attending dentist to obtain prior authorization and to provide the prior authorization number to the hospital. Failure to do so will result in denial of payment.

For prior authorization of dental services requiring hospitalization, contact WellCare’s UM Department at the telephone number listed on the *Quick Reference Guide* on WellCare’s website at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources).

**Procedures for Obtaining Prior Authorization for Transplants**

In order to receive prior authorization for a transplant, a written request with medical records must be received by WellCare for review. This pertains to liver, bone marrow, kidney and corneal transplants as well as medically necessary heart, lung and heart/lung transplants for members under the age of 21. These records must include current medical history, pertinent laboratory findings, X-ray and scan reports, social history and test results that exclude viremia and other relevant information.

Transplant procedures and related services must be approved by WellCare prior to the transplant, regardless of the age of the member. Once a transplant procedure is approved, a prior authorization number will be assigned. The member must be eligible at the time services are provided, and these services cannot be approved retroactively.
For requests for approval of coverage of all transplant services, contact WellCare’s UM Department at the telephone number listed on the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

Review and Functions for Authorized Hospitals
Hospitals must meet the federal and state requirements for control of utilization of inpatient services including:

- Authorization and re-authorization of the need for acute care;
- Treatment pursuant to a plan of care; and
- Operation of utilization review plans.

Notification of a member’s admission to a hospital allows WellCare the ability 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. Notification of an acute inpatient admission is required within one business day.

Concurrent Review
Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay for medical appropriateness utilizing appropriate criteria. The Inpatient Care Manager follows the clinical status of the member through telephonic or on-site chart review and communication with the attending physician, hospital utilization manager, care management staff or hospital clinical staff involved in the member’s care.

Concurrent review is initiated as soon as WellCare is 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; and
- Identify cases appropriate for care management.

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 nurses 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 nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

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. The
Inpatient Care Manager works with the attending physician, hospital discharge planner, 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 Care Manager may refer an inpatient member with identified complex discharge needs to Short-Term Care Management for post-discharge follow-up.

**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 Health Services’ Utilization Management Department. Refer to the Quick Reference Guide on WellCare’s website at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources).

### Standard, Expedited and Extensions of Service Authorization Decisions

<table>
<thead>
<tr>
<th>Type of Authorization</th>
<th>Initial Frame</th>
<th>Decision Time</th>
<th>Extension Length</th>
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<tbody>
<tr>
<td>Standard Pre-Service</td>
<td>2 business days</td>
<td>14 calendar days</td>
<td></td>
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<tr>
<td>Expedited Pre-Service</td>
<td>24 hours</td>
<td>48 hours</td>
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<tr>
<td>Concurrent</td>
<td>1 calendar day for initial request</td>
<td>14 calendar days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24 hours for subsequent requests</td>
<td>48 hours</td>
<td></td>
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<tr>
<td>Post-Service</td>
<td>30 calendar days</td>
<td>14 calendar days</td>
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Standard Service Authorization
WellCare is committed to processing prior authorization requests within two business 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 14 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 24 hours of the request. Requests for expedited authorization decisions should be submitted by telephone, not fax, or WellCare’s website. Please refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources for contact information.

Members and providers may submit a verbal request for an expedited 24-hour decision.

Observation
WellCare defines observation services as those services furnished by a hospital, including use of a bed and periodic monitoring by a hospital's nursing or other staff. Observation services are covered when it is determined they are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient.

Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed 24 hours. However, some patients may require 72 hours of outpatient observation services.

If the patient is not stable after 72 hours, acute care criteria will be applied.

When a member is placed under observation by a hospital, the patient is considered an outpatient until the patient is admitted as an inpatient. While under observation, the hospital may determine the patient needs further care as an inpatient admission or the patient may improve and be released. Observation is a covered revenue code on an inpatient claim.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient charges beginning from the date of initial observation. Outpatient observation services should not be used for services for which an overnight stay is normally expected. Services such as complex surgery, clearly requiring inpatient care, may not be billed as outpatient.
WellCare only covers services that are medically appropriate and necessary. Failure to obtain the required authorization will result in denial of reimbursement of all services provided and extends to all professional services, not just the hospital.

Medical appropriateness and necessity, including that of the medical setting, must be clearly substantiated in the member’s medical record. If it is determined the outpatient observation is not covered, then all services provided in the observation setting are also not covered. Services provided for the convenience of the patient or physician and that are not reasonable or medically necessary for the diagnosis are not covered.

Observation services alone do not require authorization. However, if a procedure is performed during an observation stay that requires an authorization from WellCare, the facility or provider must seek authorization approval for that procedure.

**Short-Term Care Management**

The goals of Short-Term Care Management (SCM) are 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 to reduce avoidable readmissions. The SCM will refer members with long-term needs to Complex Care Management or Disease Management.

The Short-Term Care Manager’s role is 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 Care Management to meet immediate needs and allow the member to remain in the least restrictive setting and reduce avoidable readmissions.

The SCM’s work includes, but is not limited to:

- Screening for member needs;
- Education;
- Care coordination;
- Medication reconciliation; and
- Referrals to community-based services.

Timely follow-up is critical to quickly identify and eliminate any care gaps or barriers to care.

**WellCare Proposed Actions**

A proposed action is an action taken by WellCare to deny a request for services. In the event of a proposed action, WellCare will notify the member in writing of the proposed action. The notice will contain the following:

- The action WellCare has taken or intends to take;
- The reasons for the action;
- The member’s right to appeal;
- The member’s right to request a state hearing, if applicable;
- Procedures for exercising member’s rights to appeal or file a grievance;
• Circumstances under which expedited resolution is available and how to request it; and
• 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.

**Peer-to-Peer Reconsideration of Adverse Determination**

In the event of an adverse determination following a medical necessity review, Peer-to-Peer Reconsideration is offered to the treating physician on the Notice of Action communication. The treating 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 Reconsideration is offered within three business days following the receipt of the written review determination notification by the provider.

The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration 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 are considered by WellCare to routinely be part of an office visit, such as colonoscopies, hysteroscopies and plain film X-rays.
• Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and provider offices under a Clinical Laboratory Improvement Amendment (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:
  o Reproductive laboratory tests;
  o Molecular laboratory tests; and
  o Cytogenetic laboratory tests.
• Certain tests described as CLIA-waived may be conducted in the provider’s office if the provider is authorized through the appropriate CLIA certificate. A copy of the certificate must be submitted to WellCare.

The CLIA regulations require a facility to be appropriately certified for each test performed. WellCare will deny reimbursement for any laboratory tests billed by a provider or laboratory that does not have the appropriate CLIA certificate or waiver.

All services performed without prior authorization are subject to retrospective review by WellCare.

**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 health care team, including 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 health care professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

**Individuals with Special Health Care Needs**
ISHCN are persons who have or are at high risk for a chronic physical, developmental, behavioral, neurological or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for health care or related services due to their conditions. These conditions include:
- Children in/or receiving foster care or adoption assistance;
- Blind/disabled children under age 19 and related populations eligible for SSI;
- Adults over the age of 65;
- Homelessness (upon identification);
- Individuals with chronic physical health illnesses; and
- Individuals with chronic behavioral health illnesses.

For more information, please refer to *Section 2: Provider and Member Administrative Guidelines*.

**Emergency/Urgent Care and Post-Stabilization Services**
Emergency services are not subject to prior authorization requirements and are available to WellCare members 24 hours per day, seven days per week. An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

An Emergency Medical Condition is:
A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in:
- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman having contractions:
- That there is insufficient time to effect a safe transfer to another hospital before delivery; or
- That the transfer may pose a threat to the health or safety of the woman or the unborn child.

WellCare provides payment for emergency services when furnished by a qualified provider, regardless of whether that provider is in the WellCare network. WellCare will pay for all emergency services that are medically necessary until the member is stabilized. WellCare will also pay for any medical screening examination conducted to determine whether an emergency medical condition exists. The attending emergency room provider, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.
WellCare will consider the following criteria when processing claims for emergency health care services:

- The age of the patient;
- The time and day of the week the patient presented for services;
- The severity and nature of the presenting symptoms;
- The patient’s initial and final diagnosis; and
- Any other criteria prescribed by the Department, including criteria specific to patients younger than 18 years of age.

WellCare will not retroactively deny a claim for an emergency medical screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, is subsequently determined to be non-emergent in nature. There is no single determining factor for payment liability, but rather the evaluation of service shall be based on a variety of factors including, but not limited to, the list above.

Services that are determined to be non-emergent under the prudent layperson standard are not Covered Services. However, WellCare may pay a triage fee of $50 to emergency rooms if it is determined that there was not a valid emergency using the prudent layperson standard. Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies may be denied or reimbursed at the $50 triage rate. The triage rate covers all ancillary services rendered as well as the fee for use of the emergency room. This triage rate includes any applicable member co-payment. The triage rate is for the medical screening examination and stabilization services provided in the emergency room without regard to prior authorization.

If the hospital believes the medical record supports the existence of a true emergency situation, but the initial presenting information on the claim may not be identified as a true emergency, the claim may be submitted by hard copy with documentation. A review of the documentation submitted by the provider will be conducted to determine the correct payment rate.

If a triage rate was received, and the presenting claim did not clearly provide information for determining the presence of an emergency, additional documentation may be submitted for a medical retrospective review. A single form can be submitted with one or multiple claims. Each claim submitted should contain new information which provides complete insight on the member’s visit to the emergency room. All claims will be reviewed and a follow-up letter of determination (upheld or overturned) will be sent for each claim. In the event a claim decision is overturned based on the additional documentation, WellCare will automatically reprocess the claim at the appropriate emergency room payment rate determined by the provider contract. In the event the emergency room triage decision is upheld through this informal emergency room reconsideration process, the provider can still submit the claim for review under the formal appeals process. Providers may submit all retrospective emergency room review requests utilizing the ER Medical Review Request Form.
If, after medical review, the determination is made that an emergency or potential emergency did in fact exist, the services will be reimbursed at the hospital’s specific outpatient contracted rate. Accurate coding is critical to ensure proper reimbursement.

WellCare may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but will not refuse to cover an emergency service based on the emergency room provider’s, hospital’s or fiscal agent’s failure to notify the member’s PCP, or WellCare representative, of the member’s screening and treatment within said time frames.

Once the member’s condition is stabilized, unplanned urgent admissions must be followed by notification to WellCare by calling the Provider Hotline and reporting the urgent or emergent admission within 24 hours of the admission. The caller should provide the following:

- Member’s name;
- WellCare member ID number;
- Name of admitting hospital;
- Referring provider; and
- Diagnosis of member.

Additional clinical information must be submitted to WellCare by the next business day for use in making a final authorization determination. If available, clinical information may be provided at the time of notification.

In non-emergency situations where the provider may be able to identify a chronic abuser of the emergency room, the provider may exercise its right to advise the member that they will not be accepted as a WellCare member, and, in the event the member elects to receive services, the member will be responsible for all charges incurred. If a member is not accepted for treatment as a WellCare member, hospitals should offer the following alternatives to the member:

- Refer the member to a specific alternate health care setting where he or she can obtain care the same day or next day; and
- Instruct the member as to the generally appropriate setting for treatment for such a condition in the future.

There is no limit imposed on the number of visits allowed per day per member in true medical emergencies. However, more than one non-emergency visit by the same member, to the same hospital, in one day is subject to review for medical necessity and possible denial.

Urgent care is care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Urgent care services should be provided within 48 hours.

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.
Continuity of Care
WellCare will allow members in active treatment to continue care with a terminated treating provider, when such care is medically necessary, through completion of treatment of a condition for which the member was receiving care at the time of the termination, until the member selects another treating provider, or during the next open enrollment period. None of the above may exceed six months after the termination of the provider's contract.

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 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
During the first 30 days of enrollment, authorization is not required for certain members with previously approved services by the Commonwealth or another managed care plan. WellCare 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.

When relinquishing members, WellCare will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other provider.

When WellCare becomes aware that a covered member will be disenrolled from WellCare and will transition to a Medicaid fee-for-service program or another managed care plan, a WellCare Review Nurse/Care Manager who is familiar with that member will provide a Transition of Care report to the receiving plan or appropriate contact person for the designated fee-for-service program.

If a provider receives an adverse claim determination which he or she believes was a transition of care issue, the provider should fax the adverse claim determination to the Appeals Department with documentation of approval for reconsideration. For contact information, please refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

Non-Covered Services
The following list is representative of non-covered services and procedures, and is not meant to be exhaustive:
- Any laboratory service performed by a provider without current certification in accordance with the CLIA. This requirement applies to all facilities and individual providers of any laboratory service;
Cosmetic procedures or services performed solely to improve appearance;
Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
Medical or surgical treatment of infertility (e.g., the reversal of sterilization, in vitro fertilization, etc.);
Induced abortion and miscarriage performed out of compliance with federal and Kentucky laws and judicial opinions;
Paternity testing;
Personal service or comfort items;
Post-mortem services;
Services that are investigational, mainly for research purposes, or experimental in nature. This includes, but is not limited to, drugs;
Sex transformation services;
Sterilization of a mentally incompetent or institutionalized member;
Services provided in countries other than the United States, unless approved by the Department;
Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein; and
Services for which the member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.

**Limits to Abortion, Sterilization and Hysterectomy Coverage**

**Abortion**
Abortions are covered for eligible WellCare members if the life of the mother would be endangered if the fetus were carried to term, or if the mother was a victim of rape or incest. Abortions are not covered if used for family planning purposes.

*An Abortion/Miscarriage Certification Form (MAP 235)* must be properly executed and submitted to WellCare with the provider’s claim. This form may be filled out and signed by the provider and can be found on WellCare’s website at [https://kentucky.wellcare.com/provider/forms_and_documents](https://kentucky.wellcare.com/provider/forms_and_documents).

Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted. Prior authorization is required for the administration of an abortion to validate medical necessity per federal regulations. The consent form does not need to be submitted with the request for authorization.

In addition to the above-mentioned documentation, WellCare also requires the submission of History, Physical and Operative Report and the Pathology Report with all claims that have the following *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM or its successor) codes to ensure that abortions are not being billed through the use of other procedure codes:
- 69.0  Dilation and curettage of uterus;
- 69.02 Dilation and curettage following delivery or abortion;
- 69.09 Other dilation and curettage;
- 69.5  Aspiration curettage of uterus;
• 69.52 Aspiration curettage following delivery or abortion;
• 69.59 Other aspiration curettage of uterus;
• 69.6 Menstrual extraction or regulation;
• 69.93 Insertion of Laminaria;
• 70.0 Culdocentesis;
• 72.7 Vacuum extraction;
• 72.71 Vacuum extraction with episiotomy;
• 72.79 Other vacuum extraction;
• 74.99 Other cesarean section of unspecified type; and
• 96.49 Genitourinary installation.

The following procedure codes require abortion certifications:
• 69.01 Dilation and curettage for termination of pregnancy;
• 69.51 Aspiration curettage of uterus for termination of pregnancy;
• 74.91 Hysterectomy to terminate pregnancy; and
• 75.0 Intra-amniotic injection for abortion.

Sterilizations
WellCare will not and is prohibited from making payment for sterilizations performed on any person who:
• Is under 21 years of age at the time she or he signs the consent;
• Is not mentally competent; or
• Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.

A copy of the required Sterilization Consent Form (MAP 250) is on WellCare’s website at https://kentucky.wellcare.com/provider/forms_and_documents.

Prior authorization is not required for sterilization procedures. However, WellCare will deny any provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is 30 calendar days.

The signed consent form expires 180 calendar days from the date of the member’s signature.

In the case of premature delivery or emergency abdominal surgery performed within 30 calendar days of signed consent, the provider must certify that the sterilization was performed less than 30 calendar days but not less than 72 hours after informed consent was obtained. Although these exceptions are provided, the conditions of the waiver will be subject to review.

In the case of premature delivery or emergency abdominal surgery, the sterilization consent form must have been signed by the member 30 calendar days prior to the
originally planned date of sterilization. A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to WellCare. The member must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The provider must sign the consent form after the sterilization has been performed.

The following is a list of ICD-9-CM or its successor procedure codes associated with sterilization. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the sterilization consent form is attached to those claims requiring a form:

- **Always Requires Sterilization Consent Form:**
  - 63.70 Male sterilization procedure, not otherwise specified; and
  - 66.39 Other bilateral destruction or occlusion of fallopian tubes.

- **If Done for Sterilization Purposes, Requires Sterilization Consent Form:**
  - 63.7 Vasectomy and ligation of vas deferens;
  - 63.73 Vasectomy;
  - 65.6 Bilateral salpingo-oophorectomy;
  - 65.61 Removal of both ovaries and tubes at same operative episode;
  - 65.62 Removal of remaining ovary and tube;
  - 66 Operations on fallopian tubes;
  - 66.0 Salpingostomy;
  - 66.2 Bilateral endoscopic destruction or occlusion of fallopian tubes;
  - 66.21 Bilateral endoscopic ligation and crushing of fallopian tubes;
  - 66.22 Bilateral endoscopic ligation and division of fallopian tubes;
  - 66.29 Other bilateral endoscopic destruction or occlusion of fallopian tubes;
  - 66.3 Other bilateral destruction of occlusion of fallopian tubes;
  - 66.31 Other bilateral ligation and crushing of fallopian tubes;
  - 66.32 Other bilateral ligation and division of fallopian tubes;
  - 66.4 Total unilateral salpingectomy;
  - 66.5 Total bilateral salpingectomy;
  - 66.51 Removal of both fallopian tubes at same operative episode;
  - 66.52 Removal of remaining fallopian tube;
  - 66.6 Other salpingectomy;
  - 66.63 Bilateral partial salpingectomy, not otherwise specified; and
  - 66.69 Other partial salpingectomy.

### Hysterectomy

Prior authorization is required for the administration of a hysterectomy to validate medical necessity. WellCare reimburses providers for hysterectomy procedures only when the following requirements are met:

- The provider ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the member and the attending physician must sign and date the *Hysterectomy Consent Form (MAP 251)*;
- In the case of prior sterility or emergency hysterectomy, a member is not required to sign the consent form; and
The provider submits the properly executed *Hysterectomy Consent Form (MAP 251)* with the claim prior to submission to WellCare.

Forms are located on WellCare’s website at [https://kentucky.wellcare.com/provider/forms_and_documents](https://kentucky.wellcare.com/provider/forms_and_documents).

WellCare will deny payment on any claims submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant to satisfy informed consent requirements that have been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

The following is a list of ICD-9-CM or its successor procedure codes associated with hysterectomies. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the hysterectomy acknowledgement form is attached. All hysterectomy codes listed require a hysterectomy acknowledgement form:

- 68.3 Subtotal abdominal hysterectomy;
- 68.4 Total abdominal hysterectomy;
- 68.5 Vaginal hysterectomy;
- 68.6 Radical abdominal hysterectomy;
- 68.7 Radical vaginal hysterectomy;
- 68.8 Pelvic evisceration; and
- 68.9 Other unspecified hysterectomy.

**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.

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; and
- Remedies available to WellCare if the delegated entity does not fulfill its obligations.
On an annual basis, or more frequently, audits of the delegated entity are performed to ensure compliance with WellCare’s delegation requirements.

**Care Management Program**

WellCare offers comprehensive integrated Care Management services to facilitate patient assessment, planning and advocacy in order to improve health outcomes for patients. WellCare trusts providers will help coordinate the placement and cost-effective treatment of patients who are eligible for WellCare Care Management Programs.

WellCare’s multidisciplinary Care Management teams are comprised of Care Managers who are specially trained clinicians who perform a comprehensive assessment of the member’s clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate outcomes for possible revisions of the care plan. The Care Managers work collaboratively with PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

WellCare’s Care Management teams also serve in a supportive capacity to the PCP and assist in actively linking the member to providers, medical and behavioral services, and residential, social and other support services, as needed. A provider may request Care Management services for any WellCare member.

The Care Management process begins with member identification and follows the member until discharge from the Program. Members may be identified for Care Management by:

- Referral from a member’s primary care provider or other specialist;
- Self-referral;
- Referral from a family member;
- Referral after a hospital discharge;
- After completing a Health Risk Assessment (HRA); and
- Data mining for high-risk members.

WellCare’s philosophy is that the Care Management Program is an integral management process to provide a continuum of care for WellCare members. Key elements of the Care Management process include:

- **Clinical Assessment and Evaluation** – A comprehensive assessment of the member is completed to determine where he or she is in the health continuum. This assessment gauges the member’s support systems and resources and seeks to align the member with appropriate clinical needs.

- **Care Planning** – Collaboration with the member and/or caregiver, the PCP and other providers involved in the member’s care to identify the best way to fill any identified gaps or barriers to improve access and adherence to the provider’s plan of care.

- **Service Facilitation and Coordination** – Working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation and follow-up. Behavioral health services are coordinated with the regional Community Mental Health Center (CMHC).
- **Member Advocacy** Bilateral Salpingo-oophorectomy Advocating on behalf of the member within the complex labyrinth of the health care system. Care Managers assist members with seeking services to optimize their health. Care Management emphasizes continuity of care for members through the coordination of care among physicians, CMHCs and other providers.

Members commonly identified for WellCare’s Care Management Program include those with:
- **Catastrophic Injuries** – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas.
- **Multiple Chronic Conditions** – Multiple comorbidities such as diabetes, chronic obstructive pulmonary disease (COPD) and hypertension, or multiple intricate barriers to quality health care, i.e., Acquired Immune Deficiency Syndrome (AIDS).
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up.
- **Complex Discharge Needs** – Members discharged home from acute inpatient or skilled nursing facilities (SNF) with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.
- **Special Health Care Needs** – Children or adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities.

**Disease Management Program**

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

The Disease Management Program targets the following conditions:
- Asthma – adult and pediatric;
- Coronary artery disease (CAD);
- Congestive heart failure (CHF);
- COPD;
- Diabetes – adult and pediatric;
- HIV/AIDS;
- Hypertension;
- Depression; and
- Smoking Cessation.

WellCare’s Disease Management Program educates members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid and appropriate medication management. The program also focuses on educating the provider with regards to the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of...
members, improve health outcomes and decrease medical costs. In addition, WellCare makes available to providers and members general information regarding health conditions on WellCare’s website at https://kentucky.wellcare.com/provider/default.

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

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

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

Access to Care and Disease Management Programs
If a provider would like to refer a WellCare member as a potential candidate to the Care Management Program or the Disease Management Program, or would like more information about one of the programs, he or she may call the WellCare Care Management Referral Line or complete and fax the request to the number on the Quick Reference Guide. Members may self-refer by calling the Care Management toll-free line or contacting the Nurse Advice Line after hours or on weekends (TTY available).

For more information on the Care Management Referral Line, refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.
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 WellCare’s Provider Services Department. For more information, refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

Timely Claims Submission
Unless otherwise stated in the Agreement, providers must submit claims (initialed, corrected and voided) within 12 months (or six months from the Medicaid or primary insurance payment date, whichever is later) from the date of service for outpatient services or the date of discharge for inpatient services. For more information, please refer to the Department’s website at http://www.chfs.ky.gov/dms/provider.htm. 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 the claim was electronically accepted by WellCare; and
- A provider’s electronic submission sheet with all the following identifiers: patient name, provider name, date of service to match Explanation of Benefit (EOB)/claim(s) in question, prior submission bill dates and WellCare product name or line of business.

The following items are not acceptable as evidence of timely submission:
- Strategic National Implementation Process (SNIP) Rejection Letter; and
- A copy of the provider’s billing screen.

Tax Identification and National Provider Identifier 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.hhs.gov.

Taxonomy
Providers are encouraged to submit claims with the correct taxonomy code consistent with provider’s specialty and services being rendered in order to appropriately adjudicate. WellCare may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

Preauthorization Number
If a preauthorization number was obtained, providers must include this number in the appropriate data field on the claim.
National Drug Codes
WellCare follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

Strategic National Implementation Process
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. The SNIP validations used by WellCare to verify transaction integrity/syntax are available on WellCare’s website at https://kentucky.wellcare.com/Provider/Claims_Updates.

If a claim is rejected for lack of compliance with WellCare’s claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information, see the Encounters Data Section below.

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 utilizes the ICD-9-CM or its successor mandated by CMS for all coding. 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.

Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the 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 on WellCare’s website at https://kentucky.wellcare.com/provider/resources. For more information on Covered Services under WellCare’s Kentucky Medicaid plans, refer to WellCare’s website at https://kentucky.wellcare.com/provider.

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 on WellCare’s website at https://kentucky.wellcare.com/provider/claims_updates.

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouses, refer to the WellCare Job Aids and Resource Guides, on WellCare’s website at https://kentucky.wellcare.com/provider/job_aids_and_resource_guides.

A unique WellCare Payer ID was included in the provider welcome letter from WellCare. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on WellCare Payer IDs or to contact WellCare’s EDI team, refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

HIPAA Electronic Transactions and Code Sets

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

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

For more information regarding EDI implementation with WellCare, please refer to the Wellcare Companion Guides on WellCare’s website at https://kentucky.wellcare.com/provider/claims_updates.

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 https://kentucky.wellcare.com/provider/resources.

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, handwritten or stamp any extraneous data on the form.
- In black ink;
- In a large, dark font such as PICA or ARIAL, and 10-, 11- or 12-point type; and
- In capital letters.

The typed information must not have:

- Broken characters;
- Script, italics or stylized font;
- Red ink;
- Mini font; or
- Dot matrix font.

CMS Fact Sheet about UB-04

CMS Fact Sheet about CMS-1500

Claims Processing
Seventy-Two Hour Rule
WellCare follows 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.

Disclosure of Coding Edits
WellCare utilizes clinical coding software to perform industry standard claim validity checks in accordance with all applicable rules and regulations which have been set forth by CMS (such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Manuals), the American Medical Association (AMA) and Specialty Societies. WellCare uses the claim editing software to assist in determining proper coding for provider claim reimbursement. The review process includes sending batched claim files to the vendor where the vendor compares the claim components (e.g., service codes, place of service) to the payment policies adopted by WellCare after which the vendor recommends that the incorrectly coded services receive the post-payment adjustment or denial. The outbound Explanation of Payment (EOP) contains the description explaining the edit applied to the claim line. The claim editing software programs may result in either a post-payment adjustment or a claim denial which states the reason for the denial or requests submission of medical records that relate to the claim for WellCare review. Providers may request reconsideration of any adjustment or denial by submitting a request for reconsideration to WellCare as long as it follows the dispute timely filing guidelines. A reduction in payment or a denial 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 the provider Agreement. In addition, WellCare will comply with the Prompt-Pay Statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.

**Coordination of Benefits**
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. Coordination of Benefits (COB) information can be submitted to WellCare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the EOB. 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.

If Medicaid does not have a price for codes included on a crossover claim because it is covered by Medicare but not Medicaid, the Medicare coinsurance and deductible will be paid.

**Encounters Data**
**Overview**
This section is intended to provide delegated vendors, providers and independent physician associations (IPAs) with the necessary information to allow them to submit encounter data to WellCare. If encounter data does not meet the service level agreements for timeliness of submission, completeness or accuracy, the Department 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, vendors and providers should submit complete and accurate encounter files to WellCare as follows:
- Encounters submission will be weekly;
- Capitated entities will submit within 10 calendar days of service date; and
- Non-capitated entities will submit within 10 calendar days of the paid date.

The above apply to both corrected claims (error correction encounters) and cap-priced encounters.

**Accurate Encounters Submission**
All encounter transactions submitted via Direct Data Entry (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’s or provider’s encounters, the encounters are loaded into WellCare’s Encounters System and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.


For more information regarding submitting encounters electronically, please refer to the [WellCare Companion Guides](https://kentucky.wellcare.com/provider/claims_updates) on WellCare’s website at [https://kentucky.wellcare.com/provider/claims_updates](https://kentucky.wellcare.com/provider/claims_updates).

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

**Encounters Submission Methods**

Delegated vendors and providers may submit encounters electronically, through WellCare’s contracted clearinghouse(s), via 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 [https://kentucky.wellcare.com/provider/claims_updates](https://kentucky.wellcare.com/provider/claims_updates).

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouses, refer to the *WellCare Job Aids* on WellCare’s website at [https://kentucky.wellcare.com/provider/job_aids_and_resource_guides](https://kentucky.wellcare.com/provider/job_aids_and_resource_guides).

A unique WellCare Payer ID was included in the provider welcome letter. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on the WellCare Payer IDs or to contact WellCare’s EDI team, refer to the *Quick Reference Guide* on WellCare’s website at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources).

**Submitting Encounters Using Direct Data Entry (DDE)**
Delegated vendors and providers may submit their encounter information directly to WellCare using WellCare’s DDE portal. The DDE tool can be found on the Provider Portal at https://kentucky.wellcare.com/provider. For more information on free DDE options, refer to the Provider Resource Guide on WellCare’s website at https://kentucky.wellcare.com/provider/job_aids_and_resource_guides.

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; and
- 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 replaced/overlaid encounter. The definitions of the types of encounters are as follows:

- New Encounter – A new encounter is an encounter that has never been submitted to WellCare previously.
- Voided Encounter – A voided encounter is an encounter that WellCare deletes from the encounter file and is not submitted to the state.
- Replaced or Overlaid Encounter – A replaced or overlaid encounter is an encounter that is updated or corrected within the WellCare system.

Balance Billing
Providers shall accept payment from WellCare for Covered Services provided to WellCare 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.

A provider may provide a service to a recipient on a non-Medicaid basis if the recipient agrees to receive the service on a non-Medicaid basis before the service begins and the service is not a Medicaid-covered service.

Provider-Preventable Conditions
WellCare follows CMS guidelines regarding “Hospital Acquired Conditions,” “Never Events,” and other “Provider-Preventable Conditions (PPCs).” Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.
Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

- A different procedure altogether;
- The correct procedure but on the wrong body part; or
- The correct procedure on the wrong patient.

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html) and include such events as an air embolism, falls and catheter-associated urinary tract infections.

Health care providers may not bill, attempt to collect from, or accept any payment from WellCare or the member for PPCs or hospitalizations and other services related to these non-covered procedures.

**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 Kentucky 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 Kentucky Medicaid. Providers shall accept WellCare’s payment as payment in full or will bill Kentucky Medicaid if WellCare has not assumed the Department’s financial responsibility under an agreement between WellCare and the Department.

**Claims Disputes**

The claims dispute process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes and non-covered codes, etc. Claim payment disputes must be submitted to WellCare in writing within 24 months of the date of denial of the EOP.

Documentation consists of:

- Date(s) of service;
- Member name;
- Member WellCare ID number and/or date of birth;
- Provider name;
- Provider tax ID;
- Total billed charges;
- The provider’s statement explaining the reason for the dispute; and
- Supporting documentation when necessary (e.g., proof of timely filing, medical records).

To initiate the process, please mail documentation to the address or fax it to the fax number listed in the *Quick Reference Guide* located on WellCare’s website at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources).
**Corrected or Voided Claims**

Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines.

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

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

**To submit a corrected or voided claim via paper:**
- For Institutional claims, provider must include the original WellCare claim number and bill frequency code per industry standards.

Example:

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

<table>
<thead>
<tr>
<th>REF*F8</th>
<th>117</th>
</tr>
</thead>
<tbody>
<tr>
<td>F4</td>
<td></td>
</tr>
<tr>
<td>F5</td>
<td></td>
</tr>
<tr>
<td>F6</td>
<td></td>
</tr>
<tr>
<td>F7</td>
<td></td>
</tr>
<tr>
<td>F8</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Statement Control Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>298370064</td>
</tr>
</tbody>
</table>

- For Professional claims, the 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, RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 or 8</td>
<td>123456456</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 out for the newly submitted corrected claim.

**Reimbursement**

If there are no site-of-service payment differentials specified on the Kentucky Medicaid website, WellCare applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes based on the place of treatment (provider office services versus other places of treatment).

**Surgical Payments**

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

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

- **Admission Examination**: One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.

- **Follow-up Surgery Charges**: Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.

- **Multiple Procedures**: Payment for multiple procedures is based on current CMS methodologies. When multiple surgeries are performed in a single session, reimbursement for facility services will be 100 percent of the surgical group rate for the primary procedure and 50 percent of the surgical group rate for the secondary and/or tertiary procedures. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

  - According to the *Ambulatory Surgical Centers Manual*, Transmittal #6 page 5.2, when multiple surgeries are performed in a single session, reimbursement for facility services will be 100 percent of
the surgical group rate for the primary procedure and 50 percent of the surgical group rate for the secondary procedure.

- **Assistant Surgeon**: If there are no reimbursement guidelines on the Kentucky Medicaid website for payment of assistant-at-surgery services, payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages and methodologies.

- **Co-Surgeon**: If there are no reimbursement guidelines on the Kentucky Medicaid website for payment of co-surgery procedures, payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his or 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**
If there are no reimbursement guidelines specific to a modifier(s) on the Kentucky Medicaid website, WellCare follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

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

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

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will adhere to Kentucky Revised Statutes 304.17A-708 and limit its notice of retroactive denial to 24 months from the payment receipt date. WellCare or its designee will provide a written notice to the provider identifying the specific claims, overpayment reason and amount, contact information and instructions on how to send the refund. If the retroactive denial of reimbursement 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 60 days for the provider to send in the refund, request further information or appeal the retroactive denial.
Failure of the provider to respond within the above time frames will constitute acceptance of the terms in the letter and will result in offsets to future payments. Once the overpaid balance has been satisfied, a system generated EOP will be issued. In situations where future billing is not enough to offset the entire overpaid amount, a system generated EOP will not be sent identifying the negative balance. Instead, the provider will need to contact its provider representative for account information. In situations where the overpaid balance has aged more than three months, the provider may be contacted by WellCare or its designee to arrange payment.

If providers independently identify an overpayment, they can:
- Send a corrected claim (refer to the Corrected or Voided Claim Section of this Manual);
- Contact WellCare Provider Services to arrange an offset against future payments; or
- Send a refund and explanation of the overpayment to:

  WellCare Health Plans, Inc.
  P.O. Box 31584
  Tampa, FL 33631-3584

For Provider Services contact information, please refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

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

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

This evaluation includes (as applicable to practitioner type):

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

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

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

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to WellCare members.
- Satisfactory site inspection evaluations are required to be performed in accordance with state, federal 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, the agency shall be required to meet WellCare’s criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and WellCare requirements.

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

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

**Practitioner’s Right to be Informed of Credentialing/Re-Credentialing Application Status**
Written requests for information may be emailed to credentialinginquiries@wellcare.com. Upon receipt of a written request, WellCare will provide written information to the practitioner regarding 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 or her in support of the credentialing/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 her or his application, and has the right to correct the erroneous information. WellCare will provide written notification to the practitioner of the discrepant information.

WellCare’s written notification to the practitioner includes:
- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
• The format for submitting corrections;
• The time frame for submitting the corrections;
• The addressee in Credentialing to whom corrections must be sent;
• WellCare’s documentation process for receiving the correction information from the provider; and
• WellCare’s review process.

Baseline Criteria
Baseline criteria for practitioners to qualify for provider network participation are:

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

Kentucky Medicaid Eligibility – All affiliated providers delivering Covered Services for WellCare must currently be enrolled and active as providers in the Kentucky Medicaid Program.

Drug Enforcement Administration Certificate – Providers 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 M.D., D.O., D.P.M., D.D.S., D.M.D.).

Work History – Providers must provide a minimum of five years of 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 education/training from an accredited training program in the specialty requested.

Hospital-Admitting Privileges – Specialist providers 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. In order to participate with WellCare of Kentucky, a provider must complete a participation agreement and submit all necessary credentialing information and his or her Kentucky Medicaid Provider Number. Providers are not eligible for participation if the 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 Policies and Procedures.

New Providers and Providers Not Participating in Medicaid – If a potential provider has not obtained a Kentucky Medicaid Provider Number, WellCare can facilitate a KYMAP-811 Kentucky Medicaid Enrollment Application to enroll within the network. All
documentation regarding a provider’s qualifications and services provided shall be available for review by the Department as defined in the Kentucky Contract or its agents at WellCare’s offices during business hours upon reasonable advance notice.

**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. WellCare monitors the opt-out website on an ongoing/quarterly basis.

**Liability Insurance**
WellCare providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits of $1,000,000/$3,000,000 per provider, unless otherwise agreed by WellCare in writing.

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

**Site Inspection Evaluation**
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 appearance; and
  - 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; and
- When a complaint is received relative to office site criteria.

In those states where initial SIEs are not a requirement for credentialing, there is ongoing monitoring of member complaints. 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 Providers**
Primary care physicians in solo practice must have a covering physician who also participates with or is credentialed with WellCare.
Allied Health Professionals
Allied Health Professionals (AHPs), both dependent and independent, are credentialed by WellCare.

Dependent AHPs include the following, and are required to provide collaborative practice information to WellCare:
- APRN;
- Certified Nurse Midwife (CNM);
- PA; and
- Osteopathic Assistant (OA).

Independent AHPs include, but are not limited to, the following:
- Licensed clinical social worker;
- Licensed mental health counselor;
- Licensed marriage and family therapist;
- Physical therapist;
- Occupational therapist;
- Audiologist; and
- Speech/language therapist/pathologist.

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

Re-Credentialing
In accordance with regulatory and accreditation requirements and WellCare Policies and Procedures, re-credentialing is required every three years. A notice will be sent by mail that contains a preprinted re-credentialing application and instructions 180 days before a provider’s three-year re-credentialing due date. Notwithstanding KRS 304.17A-576(3), WellCare will not make any provider participation agreement effective before the date of the completion of 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 regular and ongoing basis, WellCare or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against the network of providers. If providers are identified as being currently sanctioned, such providers are subject to immediate termination and notification of termination of contract, in accordance with WellCare Policies and Procedures.
Termination of Providers

WellCare must terminate any provider who:

- Engages in an activity that violates any law or regulation and results in suspension, termination or exclusion from the Medicare or Medicaid program;
- Has a license, certification or accreditation terminated, revoked or suspended;
- Has medical staff privileges at any hospital terminated, revoked or suspended; or
- Engages in behavior that is a danger to the health, safety or welfare of members.

In such instances, WellCare is required to notify the Department of the reason or reasons for the termination.

WellCare will notify any member of a PCP or hospital termination when the member has received a service from the terminated provider within the previous six months. The notice will be mailed within 15 days of receiving notice of the termination.

If WellCare terminates a provider for any reason not listed above, WellCare will notify members who have received a service within the previous six months. The notice will be mailed 30 days prior to the effective date of the termination.

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

On a regular and ongoing basis, WellCare or its designee contacts state licensure agencies to obtain the most current available information on sanctioned providers. This information is cross-checked against the network of WellCare providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare Policies and Procedures. 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. At least one individual on the Panel will be a participating provider and a clinical peer of the practitioner who 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 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; or
- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct, service or excessive claims and/or sanction history.

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

The practitioner has a period of up to 30 days from the date WellCare receives the notification return receipt back in the mail 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 her or his 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 therefrom, 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 she or he might otherwise have been entitled. WellCare may proceed to implement the termination and make the appropriate report to the National Practitioner Data Bank and State Licensing Agency as appropriate and if applicable.

**Delegated Entities**

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to the *Section 9: Delegated Entities* section in this Provider Manual for further details.
Section 7: Appeals and Grievances

Appeals Process

Provider

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

Providers have 30 calendar days from the original utilization management or claim denial to file an appeal. Appeals submitted after that time will be denied for untimely filing. If the provider feels she or he filed the appeal within the appropriate time frame, the provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of WellCare or similar receipt from other commercial delivery services.

Upon receipt of all required documentation, WellCare has 30 calendar days to review the appeal for medical necessity and conformity to WellCare guidelines and to render a decision to reverse or affirm. If the appeal is not resolved within 30 days, WellCare may request a 14-day extension from the provider. If the provider requests the extension, the extension shall be approved by WellCare.

Appeals received without the necessary documentation may 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 appeal 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
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 reversed. The provider will be notified of this decision in writing.

The provider may file a claim for payment related to the appeal, if one has not already been submitted. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to reverse the denial has been made. WellCare will ensure that claims are processed and comply with federal and state requirements.
**Affirmation of Denial**

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

For denials based on medical necessity, the criteria used to make the decision will be provided in the letter. The provider may also request a copy of the benefit provision, guideline, protocol and other similar criteria used in making the appeal decision by sending a written request to the appeals addresses listed in the decision letter.

**Member Appeals Process**

**Overview**

A member appeal is a formal request from a member for a review of an action taken by WellCare. An appeal may also be filed on the member’s behalf by an authorized representative or a provider with the member’s written consent. All appeal rights described in *Section 7: Appeals and Grievances* of this Provider Manual that apply to members will also apply to the member’s authorized representative or a provider acting on behalf of the member with the member’s written consent. To appeal, the member may file an appeal request either orally via WellCare’s Customer Service or in writing within 30 calendar days of the date of the adverse determination.

If an appeal is filed orally via WellCare’s Customer Service, the request must be followed up with a written, signed appeal to WellCare within 10 calendar days of the oral filing. For oral filings, the time frames for resolution begin on the date the oral filing was received by WellCare. Unless written confirmation of a standard oral appeal request is received, the case is closed as an invalid appeal and a decision is not made on the 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;
- 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 Department;
- The failure of WellCare to complete the authorization request in a timely manner as defined in 42 CFR 438.408; and
- For a resident of a rural area with only one plan, the denial of a member’s request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.

If the member’s request for appeal is submitted after 30 calendar days, then good cause must be shown in order for WellCare to accept the late request. Examples of good cause include, but are not limited to, the following:

- The member did not personally receive the notice of action 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; and/or
• The member had incorrect or incomplete information concerning the appeal process.

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

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

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.

Types of Appeals
A member may file for a standard pre-service, retrospective or an expedited appeal determination.

Standard pre-service appeals are requests for services that WellCare has determined are not Covered Services, are not medically necessary, or are otherwise outside of the member’s benefit plan.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the member has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review. These are the only appeals that may be made by the provider on his or her own behalf.

Only pre-service appeals may be expedited.

Appointment of Representative
If the member wishes to use a representative, then she or he must complete an Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on WellCare’s website at https://kentucky.wellcare.com/provider/forms_and_documents.

Appeal Decision Time Frames
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:
• Standard Pre-Service Request: 30 calendar days
• Retrospective Request: 30 calendar days
• Expedited Request: 72 hours

The standard pre-service, expedited and retrospective determination periods noted above may be extended by up to 14 calendar days if the member requests an extension
or if WellCare 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, WellCare will provide the member with written notice of the reason for the delay within two business days of the decision to extend the time frame.

**Standard Pre-Service and Retrospective Appeals Process**
A member may file a standard pre-service or retrospective appeal determination. A member may also present his or her appeal in person.

**Standard Pre-Service or Retrospective Appeal Decisions**
If WellCare reverses its original decision denying a member’s request for a service (pre-service request), then WellCare will issue an authorization for the pre-service request or send payment if the service has already been provided.

If WellCare affirms its initial action and/or denial (in whole or in part), it will:
- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in easily understandable language with reference to the benefit provision, guidelines, protocol or other similar criteria on which the appeal decision was based;
- Inform the member:
  - Of the right to request a State Fair Hearing and how to do so;
  - Of the right to representation;
  - Of the right to continue to receive benefits pending a State Fair Hearing; and
  - That he or she may be liable for the cost of any continued benefits if WellCare’s action is upheld.

**Expedited Appeals Process**
To request an expedited appeal, a member or a provider (regardless of whether the provider is affiliated with WellCare) must submit an oral or written request directly to WellCare. A request to expedite an appeal 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.

Members who orally request an expedited appeal are not required to submit a written appeal request.

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

WellCare will provide the member with prompt oral notification within 24 hours regarding the denial of an expedited request and will follow-up with written notification to the member within two calendar days which:
- 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.
Upon acceptance of an expedited appeal, 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 72 hours after receiving a valid, complete request for 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 orally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

**Denial of an Expedited Appeal Request**

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

- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in easily understandable language with reference to the benefit provision, guidelines, protocol or other similar criteria on which the appeal decision was based;
- Inform the member:
  - Of the right to request a State Fair Hearing and how to do so;
  - Of the right to representation;
  - Of the right to continue to receive benefits pending a State Fair Hearing; and
  - That she or he may be liable for the cost of any continued benefits if WellCare’s action is upheld.

**State Fair Hearing for Members**

A member or his or her authorized representative may request a State Fair Hearing if he or she is dissatisfied with an action that has been taken by WellCare. The hearing request must be post marked within 45 calendar days from the date of the Plan’s final decision letter.

If the member wishes to use a representative, she or he must complete an Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on WellCare’s website at [https://kentucky.wellcare.com/provider/forms_and_documents](https://kentucky.wellcare.com/provider/forms_and_documents).

Please note that all members must exhaust all internal WellCare appeal rights prior to requesting a State Fair Hearing.

State Fair Hearings are not the appropriate forum for billing or payment disputes. For process of appeal of a claims payment or grievance, please see Section 5: Claims.

All documents supporting WellCare’s action must be received by the Department no later than five days from the date WellCare receives notice from the Department that a State Fair Hearing request has been filed. These records shall be made available to the member upon request by either the member or the member’s authorized representative. The Department will provide the member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.
Failure of WellCare to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an action taken by WellCare or to appear and present evidence will result in an automatic ruling in favor of the member.

**Continuation of Benefits while the Appeal and Medicaid Fair Hearing Are Pending**

WellCare shall continue the member’s benefits if all of the following are met:

- The member or the service provider files a timely appeal of the WellCare action or the member requests a State Fair Hearing within 45 days from the date on WellCare’s notice of action;
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized service provider;
- The time period covered by the original authorization has not expired; and
- The member requests extension of the benefits.

WellCare shall provide benefits until one of the following occurs:

- The member withdraws the appeal;
- 14 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the member and the member has not requested a State Fair Hearing or taken any further action;
- The Department issues a State Fair Hearing decision adverse to the member; and/or
- The time period or service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member and WellCare’s action is upheld, WellCare may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

If WellCare or the Department reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, WellCare will authorize or provide the appealed services promptly, as expeditiously as the member’s health condition requires.

If WellCare or the Department reverses a decision to deny, limit or delay services and the member receives the appealed services while the appeal is pending, WellCare will pay for those services.

**Grievance Process**

**Provider**

Providers have the right to file a grievance no later than 30 calendar days from the date the provider becomes aware of the issue generating the grievance. Written resolution will be provided to the provider within 30 calendar days from the date the grievance is received by WellCare. If additional time is needed, WellCare shall orally request a 14-day extension from the provider. If the provider requests the extension, the extension shall be approved by WellCare.
A provider may not file a grievance on behalf of the member without written consent from the member.

WellCare will provide all providers written notice of the provider grievance procedures at the time they enter into contract.

For more information, see the *Grievance Submission* section below.

**Member**

A member or a member’s representative, including the legal guardian of a minor member or incapacitated adult or a provider acting on behalf of the member with written consent, has the right to file a grievance request either orally or in writing within 30 calendar days of the date of the incident or when the member was made aware of the incident. WellCare will acknowledge the member or member’s representative grievance in writing within five business days from the date the grievance is received by WellCare. The acknowledgement letter will include:

- Name and telephone number of the Grievance Coordinator;
- The expected date of the grievance resolution; and
- A request for any additional information needed to investigate the issue.

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); and/or
  - Office conditions.
- **Services provided by WellCare** including, but not limited to:
  - Hold time on telephone;
  - Rudeness of staff;
  - Involuntary disenrollment from WellCare; and/or
  - Unfulfilled requests.
- **Access availability** including, but not limited to:
  - Difficulty getting an appointment;
  - Wait time in excess of one hour; and/or
  - Handicap accessibility.

Upon receipt of the grievance, a written resolution will be mailed to the member within 30 calendar days from the date the grievance is received by WellCare. 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 letter. The resolution letter will include:

- The results/findings of the resolution;
- All information considered in the investigation of the grievance; and
- The date of the grievance resolution.

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, she or he must complete an Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on WellCare’s website at https://kentucky.wellcare.com/provider/forms_and_documents.

**Grievance Submission**
An oral grievance request shall be filed through the established toll-free number to the WellCare Customer Service Department. An oral request may be followed up with a written request by the member, but the time frame for resolution begins the date the oral filing is received by WellCare. A written provider grievance shall be mailed directly to WellCare’s Grievance Department at:

WellCare of Kentucky  
Attention: Grievance Department  
P.O. Box 436000  
Louisville, KY 40253

For the submission address, telephone and fax number, please refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

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

An extension may be requested up to 14 calendar days by the member’s or the member’s representative. WellCare may also initiate an extension if it can justify the need for additional information and it is in the member’s best interest. In all cases, extensions must be well-documented. WellCare will provide the member or the member’s representative written notification regarding WellCare’s decision to extend the time frame within two working days with the decision to extend the time frame of the grievance resolution.

**State Fair Hearing for Members**
A member has 45 calendar days to request a State Fair Hearing if WellCare fails to act within the 45 calendar day time frame of resolving and providing a written resolution to the member’s grievance request.

All documents supporting WellCare’s decision must be received by the Department no later than five days from the date WellCare receives notice from the Department that a State Fair Hearing has been filed by the member. These records shall be made available to the member upon request by either the member or the member’s legal counsel. The
Department will provide the member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.

Failure of WellCare to comply with the State Fair Hearing requirements of the Commonwealth and federal Medicaid law in regard to an action taken by WellCare or to appear and present evidence will result in an automatic ruling in favor of the member.

**Grievance and Appeal Files**
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for 10 years following the final decision by WellCare, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

Files will contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the member of receipt of the grievance or appeal, all correspondence between WellCare and the member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the member and all other pertinent information.

Documentation regarding the grievance shall be made available to the member, if requested.
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 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 disciplinary actions to address violations.

- Corporate Integrity Agreement (CIA) Training
  - Effective April 26, 2011, WellCare’s CIA with the OIG of the U.S. Department of Health and Human Services (DHHS) requires that WellCare maintain and build upon its existing Compliance Program and corresponding training.
  - Under the CIA, the degree to which individuals must be trained depends on their role and function at WellCare.

- HIPAA Privacy and Security Training
  - To encompass privacy and security requirements in accordance with the federal standards established pursuant to HIPAA.
  - Must include, but is not limited to:
    - Uses and disclosures of PHI;
    - Member rights; and
    - Physical and technical safeguards.

- Fraud, Waste and Abuse (FWA) Training
  - Must include, but is not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback Statute, HIPAA, etc.);
    - Obligations of the provider, including provider employees and provider sub-contractors and their employees, to have appropriate policies and procedures to address fraud, waste and abuse;
    - Process for reporting suspected fraud, waste and abuse;
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
    - 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 WellCare’s website at http://www.wellcare.com/AboutUs/default.

**Code of Conduct and Business Ethics**

**Overview**
WellCare has established a [Code of Conduct and Business Ethics](http://www.wellcare.com/AboutUs/default) 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 [http://www.wellcare.com/AboutUs/default](http://www.wellcare.com/AboutUs/default).

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 WellCare's 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 suspicions of 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 health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. WellCare has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of health care service use, including overutilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement and WellCare vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding and other activities designed to manipulate codes contained in the ICD-9-CM or its successor, CPT-4, the 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 https://kentucky.wellcare.com/provider/resources or call WellCare’s confidential and toll-free compliance hotline. Details of the Corporate Ethics and Compliance Program, and how to contact the WellCare fraud hotline, may be found on WellCare’s website at http://www.wellcare.com/AboutUs/default.

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 her or his 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 the confidentiality of members’ medical records and other PHI and that 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. Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Every provider practice is required to provide members with a 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 health care providers, to provide a NPP to each new patient or member.

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 as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
• Any communication with other clinical persons involved in the member’s health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc);
• Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
• Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law.

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 health care activities.

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

For more information on how to request this information, members may contact WellCare’s Customer Service using the toll-free telephone number found on the member’s ID card. Providers may contact WellCare’s Customer Service by referring to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

Provider Education and Outreach
Providers may:
• Display state-approved, WellCare-specific materials in-office;
• Announce a new affiliation with a health plan; and
• 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:
• Orally, or in writing, comparing benefits or provider 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, including WellCare, or any other entity; and
• Assisting with health plan enrollment.

All subcontractors and providers must submit any marketing or information materials which refer to WellCare by name to WellCare for approval prior to disseminating the materials.
Section 9: Delegated Entities

Overview
WellCare oversees the provision of services provided by the delegated entity and/or subcontractor, and is accountable to federal and state agencies, including the Department, for the performance of all delegated functions. It is the sole responsibility of WellCare to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and WellCare Policies and Procedures.

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

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

Refer to Section 8: Compliance for additional information on compliance requirements.

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

- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs;
- Ensure that WellCare has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and WellCare, reporting requirements, and delegated activities in a clear and understandable manner;
- Ensure that the appropriate WellCare associates have properly evaluated the entity’s ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity’s performance at least annually, including monitoring, to ensure quality of care and quality of service is not compromised by financial incentives;
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity’s performance is inadequate;
- Assure the delegated entity is in compliance with the requirement in 42 CFR 438;
- Assure that each delegated entity or delegated subcontractor contract:
  - Identifies the population covered by the delegated entity;
  - Specifies the amount, duration and scope of services to be provided by the delegated entity;
  - Specifies the term, procedures and criteria for termination;
  - Specifies that delegated entities use only Commonwealth-participating Medicaid providers in accordance with the Kentucky Contract;
  - Makes full disclosure of the method and amount of compensation or other consideration to be received from WellCare;
  - Provides for monitoring by WellCare of the quality of services rendered to members, in accordance with the Kentucky Contract;
Where the delegated entity agrees to provide Covered Services, contains no provision that provides incentives, monetary or otherwise, for the withholding from members of medically necessary Covered Services;

Contains a prohibition on assignment, or on any further subcontracting, without the prior written consent of WellCare;

Contains an explicit provision that the Commonwealth is the intended third party beneficiary of the contract WellCare has with delegated entity and, as such, the Commonwealth is entitled to all remedies entitled to third party beneficiaries under law;

Specifies that delegated entity agrees to submit encounter records in the format specified by the Commonwealth so that WellCare can meet the Commonwealth’s specifications required by the Kentucky Contract;

Incorporates all the provisions of the Kentucky Contract to the fullest extent applicable to the service or activity delegated pursuant to the delegated entity contract, including without limitation, the obligation to comply with all applicable federal and Commonwealth laws and regulations, including, but not limited to, KRS 205.8451-8483, all rules, Policies and Procedures of Finance and the Department as defined in the Kentucky Contract, and all standards governing the provision of Covered Services and information to members, all QI Program requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements and all obligations upon termination;

Provides for WellCare to monitor the delegated entity’s performance on an ongoing basis, including those with accreditation, the frequency and method of reporting to WellCare, the process by which WellCare evaluates the delegated entity’s performance, and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;

Specifies that a delegated entity with NCQA®, URAC or other national accreditation shall provide WellCare with a copy of its current certificate of accreditation together with a copy of the survey report;

Provides a process to identify deficiencies or areas of improvement and any necessary corrective action;

Specifies the remedies up to and including revocation of the delegated contract available to WellCare if the delegated entity does not fulfill its obligations; and

Contains provisions that suspected fraud and abuse be reported to WellCare.
Section 10: Behavioral Health

Overview
WellCare provides a behavioral health benefit for Medicaid plans. All provisions contained within the Provider Manual are applicable to medical and behavioral health providers unless otherwise noted in this section.

Behavioral Health Program
Some behavioral health services may require prior authorization including those services provided by non-participating providers. WellCare uses InterQual™ criteria, a well-known and nationally accepted guideline for assessing level of care criteria for behavioral health.

For complete information regarding benefits, exclusions and authorization requirements, or if a provider needs to contact WellCare’s Provider Services for a referral to a behavioral health provider, please refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

Responsibilities of Behavioral Health Providers
WellCare monitors providers against the standards below 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>Behavioral Health Provider – Non-Life-Threatening Emergency</td>
<td>&lt; 6 hours</td>
</tr>
<tr>
<td>Behavioral Health Provider – Crisis Stabilization</td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td>Behavioral Health Provider – Urgent</td>
<td>&lt; 48 hours</td>
</tr>
<tr>
<td>Behavioral Health Provider – Post Inpatient Psychiatric Discharge</td>
<td>&lt; 7 days</td>
</tr>
<tr>
<td>Behavioral Health Provider – Regular Appointments</td>
<td>&lt; 10 days</td>
</tr>
<tr>
<td>Behavioral Health Provider – Other Referrals</td>
<td>&lt; 60 days</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 7 days from the date of discharge.

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 per day. The behavioral crisis phone number is printed on the member’s ID card and is available on WellCare’s website.

For information about WellCare’s Care Management and Disease Management Programs, including how to refer a member to these services, please see Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM).

Behavioral providers are required to use the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) multiaxial classification when assessing the member for behavioral health services and document the DSM-IV diagnosis and assessment/outcome information in the member’s medical record.

**Continuity and Coordination of Care Between Medical and Behavioral Health Care**

WellCare will work with PCPs to ensure appropriate screening and evaluation procedures for the detection and treatment of or referral for any known or suspected behavioral health problems. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if and when they are licensed to do so within the scope of their practice. However, if they are unable to treat the member’s physical health, behavioral health providers should refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member’s or the member's legal guardian’s consent.

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 member’s identified PCP noting any changes in the treatment plan on the day of discharge.

WellCare strongly encourages open communication between PCPs and behavioral health providers. If a member's medical or behavioral condition changes, WellCare expects 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.

**Behavioral Health Advisory Council**

WellCare values the input of its behavioral health members, advocates and providers. A behavioral health advisory council has been established in order to assure that services and programs meet the needs and expectations of the behavioral health community. WellCare encourages its providers to participate by providing feedback and input to the advisory council. Information regarding the advisory council will be made available on WellCare’s website at https://kentucky.wellcare.com/provider/behavioral_health.
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;
- Quantity Limit;
- Age Limit;
- Pharmacy Lock-In Program;
- Coverage Determination Review Process;
- Network Improvement Program (NIP); and
- 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 patients get the most out of their pharmacy benefit, providers are encouraged to 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) VIII Hypertension guidelines;
- Prescribe drugs listed on the PDL;
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class; and
- Evaluate medication profiles for appropriateness and duplication of therapy.

To contact WellCare’s Pharmacy Department, please refer to the Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

Preferred Drug List
The PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmaceutical and Therapeutics Committee (P&T Committee). The PDL denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

The P&T Committee selects drugs 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 and step therapy).

The PDL is on WellCare’s website at https://kentucky.wellcare.com/provider/pharmacy. Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to providers via the following:

- Quarterly updates in provider and member newsletters;
- Website updates; and/or
• 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 WellCare’s PDL, providers may write or fax WellCare, explaining the medical justification. For contact information, refer to the *Quick Reference Guide* on WellCare’s website at https://kentucky.wellcare.com/provider/resources.

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 medications must be dispensed by the pharmacist when available as the therapeutic equivalent to a brand-name drug. To request an exception to the mandatory generic policy, a *Coverage Determination Request Form* should be submitted. Clinical justification as to why the generic alternative is not appropriate for the member should be included with the *Coverage Determination Request Form*.

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 medications are recognized as safe, effective and economically sound treatments. The first-line medications on WellCare’s PDL have been evaluated through the use of clinical literature and are approved by WellCare’s 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 the Food and Drug Administration (FDA)-approved dosing guidelines. Quantity limits are also used to help prevent billing errors.

The PDL identifies medications with quantity limits.
Age Limits
Some drugs have an age limit associated with them. WellCare utilizes age limits to help ensure proper medication utilization and dosage, when necessary.

The PDL identifies medications with age limits.

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 prescribing physician and one pharmacy to obtain their medications. Claims submitted by other prescribers or other pharmacies will not be paid for the member. Members identified will also be referred to Care Management.

Members in the Lock-In program will be reviewed annually by the P&T Committee who shall determine the need for further lock-in according to established procedures and federal regulations regarding such action.

Coverage Determination Review Process
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 requiring prior authorization;
- Brand-name drugs when a generic exists; and
- Drugs that have a step therapy edit and the first-line therapy is inappropriate.

Providers may request an exception to WellCare’s PDL orally 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 WellCare’s website at https://kentucky.wellcare.com/provider/forms_and_documents.

To submit a request, orally or in writing, refer to the contact information listed on the provider Quick Reference Guide on WellCare’s website at https://kentucky.wellcare.com/provider/resources. Upon receipt of the Coverage Determination Request Form, a decision is completed within 24 hours. If authorization cannot be approved or denied, and the drug is medically necessary, 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.). The criteria are available upon request when submitted to the Pharmacy Department by the member or provider.

**Injectable and Infusion Services**
Select self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Most self-injectable products and all infusion drug requests 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 for self-injectable products that do not require authorization when administered in a doctor’s office are included on the website at [https://kentucky.wellcare.com/provider/pharmacy](https://kentucky.wellcare.com/provider/pharmacy). The *Injectable Infusion Form* is on WellCare’s website at [https://kentucky.wellcare.com/Provider/Forms_and_Documents](https://kentucky.wellcare.com/Provider/Forms_and_Documents).

**Medication Appeals**
To request an appeal of a Coverage Determination Review decision, contact the Pharmacy Appeals Department via fax, mail, in person or by phone. Refer to the *Quick Reference Guide* on WellCare’s website at [https://kentucky.wellcare.com/provider/resources](https://kentucky.wellcare.com/provider/resources).

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*.

**Coverage Limitations**
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;
- Drugs for the treatment of erectile dysfunction;
- DESI drugs or drugs that may have been determined to be identical, similar or related;
- Multivitamins with fluoride (with or without iron) for members over age 16;
- Investigational or experimental drugs; and
- Agents prescribed for any indication that is not medically accepted.

WellCare will not reimburse for prescriptions for refills too soon, duplicate therapy or excessively high dosages for the member.

**Over-the-Counter Medications**
Over-the-counter (OTC) items listed on the PDL require a prescription. All other OTC items offered as an expanded benefit by WellCare do not require a prescription. Examples of OTC items listed on the PDL include:
- Multivitamins and multiple vitamins with iron (chewable or liquid drops);
• Iron;
• Non-sedation antihistamines;
• Enteric coated aspirin;
• Diphenhydramine;
• Insulin;
• Topical antifungals;
• Ibuprofen suspension;
• Permethrin;
• Meclizine;
• Insulin syringes;
• Urine test strips;
• H-2 receptor antagonists; and
• Proton pump inhibitors.

For a complete listing, please refer to the PDL on WellCare’s website at https://kentucky.wellcare.com/provider/pharmacy.

In addition to OTC products listed on the PDL, each household, on a monthly basis, is entitled to order $10 worth of products from the Over-The-Counter catalog free of charge. Directions for ordering and catalog are available at: https://kentucky.wellcare.com/member/benefit_information.

**Member Co-Payments**

• $4 for non-preferred brand drugs (those not listed on the PDL);
• $0 for preferred brand drugs (those listed on the PDL);
• $0 for preferred generic drugs (those listed on the PDL);
• $0 for birth control and smoking cessation medications; and
• $0 for members under 21 years of age.

**Pharmacy Management – Network Improvement Program**

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 practices 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 per day.

For areas where there are no pharmacies open 24 hours per day, members may call Catamaran for information on how to access pharmacy services. Contact information is also located on the *Quick Reference Guide* on WellCare’s website at https://kentucky.wellcare.com/provider/resources.
**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 teams are experts 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 WellCare's website at [https://kentucky.wellcare.com/provider/pharmacy](https://kentucky.wellcare.com/provider/pharmacy).
Section 12: Definitions and Abbreviations

Definitions

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

“Abuse” means Provider Abuse and Member Abuse, as defined in KRS 205.8451.

“Action” means, as defined in 42 CFR 438.400(b), the
A. Denial or limited authorization of a requested service, including the type or level of service;
B. Reduction, suspension, or termination of a service previously authorized by the Department, its agent or WellCare;
C. Denial, in whole or in part, of payment for a service;
D. Failure to provide services in a timely manner, as defined by Department;
E. Failure of a WellCare or Prepaid Health Insurance Plan (PHIP) to act within the time frames required by 42 CFR 438.408(b); or
F. For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside WellCare’s region.

“Appeal” means a request for review of an Action or a decision by or on behalf of WellCare related to the Covered Services or services provided including EPSDT services.

“Authorization” means an approval of a prior authorization request for payment of services, and is provided only after WellCare agrees the treatment is necessary.

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

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

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

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

“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 items and services covered under a Benefit Plan.

“Department” means the Department for Medicaid Services.

“EPSDT” means Early and Periodic Screening, Diagnosis and Treatment program that provides medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a) to all members under the age of 21.

“EPSDT Special Services” means medically necessary services which are not otherwise covered by the Kentucky Medicaid Program under EPSDT Covered Services.

“Emergency Medical Condition” means
- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman having contractions:
  - That there is an inadequate time to effect a safe transfer to another hospital before delivery; or
  - That transfer may pose a threat to the health or safety of the woman or the unborn child.

“Emergency Medical Services” or “Emergency Care” means care for a condition as defined in 42 USC 1395dd and 42 CFR 438.114.

“Encounter Data” means encounter information, data and reports for Covered Services provided to a member that meets the requirements for clean claims.
“Grievance” means any complaint or dispute, other than one that involves a WellCare determination, expressing dissatisfaction with any aspect of the operations, activities or behavior of WellCare, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

“Ineligible Person” means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or 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 Health Care Programs described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in state medical assistance programs, including Medicaid or CHIP, or state procurement or non-procurement programs as determined by a State Governmental Authority.

“Kentucky Contract” means the Medicaid Managed Care Contract between the Commonwealth of Kentucky, Finance and Administration Cabinet and WellCare of Kentucky, Inc., and any amendments, including corrections or modifications thereto.

“LTAC” means a Long-Term Acute Care hospital.

“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 with Special Health Care Needs” means members with special needs 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.

“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 time frames for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program.

“PCP” or “Primary Care Provider” means a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse, physician assistant, or health clinic, including an FQHC, primary care center, or RHC that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing
admitting privileges, and agrees to provide 24 hours per day, seven days per week primary health care services to individuals, and for a member who has a gynecological or obstetrical health care needs, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

“Prior Authorization” means the process of obtaining authorization in advance of a planned inpatient admission or an outpatient procedure or service. An authorization decision is based on clinical information provided with the request. WellCare may request additional information, including a medical record review.

“Provider” means an individual or entity that has contracted to provide or arrange for the provision of Covered Services to members under a benefit plan.

“Screening” means the review of the health and health-related conditions of a recipient by a health care professional to determine if further diagnosis or treatment is needed.

“Service” means health care, treatment, a procedure, supply, item or equipment.

“Service Location” means any location at which a member may obtain any Covered Services from a provider.

“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.

Abbreviations

AAP – American Academy of Pediatrics
ABD – Aged, Blind or Disabled
ACIP – Advisory Committee on Immunization Practices
ACS – American College of Surgeons
Agreement – Provider Participation Agreement
AHP – Allied Health Professionals
AIDS – Acquired Immune Deficiency Syndrome
AMA – American Medical Association
AOR – Appointment of Representative
APRN – Advanced Practice Registered Nurse
ASC – Ambulatory Surgical Centers
CAD – Coronary Artery Disease
CAP – Corrective Action Plan
CHF – Congestive Heart Failure
CHIP – Children’s Health Insurance Plan
CIA – Corporate Integrity Agreement
CLAS – Culturally and Linguistically Appropriate Services
CLIA – Clinical Laboratory Improvement Amendment
CM – Case Management
CMHC – Community Mental Health Center
CMS – Centers for Medicare & Medicaid Services
CNM – Certified Nurse Midwife
COPD – Chronic Obstructive Pulmonary Disease
DDE – Direct Data Entry
DEA – Drug Enforcement Administration
Department – Kentucky Cabinet for Health and Family Services, Department for Medicaid Services
DHHS – United States Department of Health and Human Services
DM – Disease Management
DME – Durable Medical Equipment
DOC – Delegation Oversight Committee
DSM-IV – Diagnostic and Statistical Manual, Fourth Edition
EDI – Electronic Data Interchange
EOB – Explanation of Benefits
EOP – Explanation of Payment
EPSDT – Early and Periodic Screening, Diagnosis, and Treatment
ER – Emergency Room
ESRD – End Stage Renal Disease
FDA – Food and Drug Administration
FQHC – Federally Qualified Health Center
FWA – Fraud, Waste and Abuse
HCPCS – Healthcare Common Procedure Coding System
HEDIS® – Healthcare Effectiveness Data and Information Set
HIPAA – Health Insurance Portability and Accountability Act of 1996
HIV – Human Immunodeficiency Virus
HMO – Health Maintenance Organization
HRA – Health Risk Assessment
ICD-9-CM – *International Classification of Diseases, 9th Revision, Clinical Modification*
IEP – Individualized Education Plan
IPAs – Independent Physician Associations
ISHCN – Individuals with Special Health Care Needs
IVR – Interactive Voice Response system
JNC – Joint National Committee
KCHIP – Kentucky Children’s Health Insurance Program
LTAC – Long-Term Acute Care
MCO – Managed Care Organization
NCCI – National Correct Coding Initiative
NCQA® – National Committee for Quality Assurance
NDC – National Drug Codes
NIH – National Institutes of Health
NIP – Network Improvement Program
NPI – National Provider Identifier
NPP – Notice of Privacy Practices
OA – Osteopathic Assistant
OB – Obstetrical/Obstetrician
OB-GYN – Obstetrician/Gynecologist
OIG – Office of Inspector General
OT – Occupational Therapy
OTC – Over-The-Counter
P&T Committee – Pharmaceutical and Therapeutics Committee
PA – Physician Assistant
PCC – Primary Care Clinic
PCP – Primary Care Provider
PDL – Preferred Drug List
PHI – Protected Health Information
PPC – Provider Preventable Condition
Provider ID – Provider Identification
PRTF – Psychiatric Residential Treatment Facility
PT – Physical Therapy
QI Program – Quality Improvement Program
RHC – Rural Health Clinic
SCM – Short-Term Case Management
SFTP – Secure File Transfer Protocol
SIE – Site Inspection Evaluations
SNF – Skilled Nursing Facility
SNIP – Strategic National Implementation Process
SSI – Supplemental Security Income
SSN – Social Security Number
ST – Speech Therapy
TB – Tuberculosis
TIN/Tax ID - Tax Identification Number
TTY – Telephone Typewriter
UM – Utilization Management
VFC – Vaccines for Children
WEDI – Workgroup for Electronic Data Interchange
WIC – Women, Infants and Children Program
Section 13: WellCare Resources

WellCare of Kentucky Homepage
https://kentucky.wellcare.com

Provider Manual and Other Provider Resources
https://kentucky.wellcare.com/provider/resources

Forms and Documents
https://kentucky.wellcare.com/provider/forms_and_documents

Quick Reference Guide
https://kentucky.wellcare.com/provider/resources

Clinical Practice Guidelines
http://www.wellcare.com/provider/CPGs

Clinical Coverage Guidelines
http://www.wellcare.com/provider/CCGs

Job Aids and Resource Guides
https://kentucky.wellcare.com/provider/job_aids_and_resource_guides

Claims Updates
https://kentucky.wellcare.com/provider/claims_updates

Pharmacy
https://kentucky.wellcare.com/provider/pharmacy

Quality
https://kentucky.wellcare.com/provider/quality

Behavioral Health
https://kentucky.wellcare.com/provider/behavioral_health