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Section 1: Overview

About Missouri Care
Since 1998, Missouri Care, a WellCare Company, has worked with the MO HealthNet Division to improve Member access to cost-effective, quality healthcare for eligible MO HealthNet participants in all MO HealthNet managed care counties in the state of Missouri. We established a strong record of improving the health of Missourians through increased accessibility, high-quality care, effective communications and Member-centered wellness and care management programs.

We offer integrated physical and behavioral health (including substance abuse) programs, using sophisticated risk assessment tools to develop proactive, preventive plans of care for individuals. Our comprehensive Care Management Programs, designed specifically for MO HealthNet populations, are extremely successful in increasing access to care, improving clinical outcomes and reducing costs. We are proficient at communicating with Members and Providers, and at building long-lasting relationships with stakeholders. Our focus on the individual and our commitment to personalized care enables Missouri Care to create a healthcare environment that empowers Members to take responsibility for their own healthcare and supports them in reaching their personal health goals.

Missouri Care is accredited by the National Committee for Quality Assurance (NCQA), a private non-profit organization dedicated to improving healthcare quality.

About WellCare
WellCare Health Plans, Inc., (WellCare) provides managed care services targeted exclusively to government-sponsored healthcare programs, focused on Medicaid and Medicare, including prescription drug plans, health plans for families, and the aged, blind and disabled. WellCare’s corporate office is located in Tampa, Florida. WellCare serves approximately 5.5 million Members. Our experience and commitment to government-sponsored healthcare programs enable us to serve our Members and Providers as well as manage our operations effectively and efficiently.

Mission and Vision
WellCare’s vision is to be the leader in government-sponsored healthcare programs in partnership with the Members, Providers, governments and communities we serve. WellCare will:

- Enhance our Members’ health and quality of life;
- Partner with Providers and governments to provide quality, cost-effective healthcare solutions; and
- Create a rewarding and enriching environment for our associates.

Our Values are:
- **Partnership** – Members are the reason we are in business; Providers are our partners in serving our Members; and regulators are the stewards of the public’s resources and trust. We will deliver excellent service to our partners.
- **Integrity** – Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.
• Accountability – All associates must be responsible for the commitments we make and the results we deliver.
• One Team – With our fellow associates, we can expect – and are expected to demonstrate – a collaborative approach in the way we work.

Purpose of this Manual
This Provider Manual is intended for Missouri Care-contracted (participating) Medicaid Providers providing healthcare service(s) to enrolled Missouri Care Members. This manual serves as a guide to the policies and procedures governing the administration of Missouri Care’s Medicaid plans and is an extension of and supplements the Provider Contract (Contract) between Missouri Care and healthcare Providers who include, without limitation: physicians, hospitals and ancillary Providers (collectively, Providers). This manual replaces and supersedes any previous versions dated prior to February 22, 2019 and is available on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid. A paper copy, at no charge, may be obtained upon request by contacting Provider Services or your Provider Relations representative.

In accordance with the Policies and Procedures clause of the Provider Contract, participating Missouri Care Medicaid Providers must abide by all applicable provisions contained in this manual. Revisions to this manual reflect changes made to Missouri Care’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 Missouri Care to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by Missouri Care in the form of provider bulletins posted to the provider portal on Missouri Care’s website; subsequent manual updates that include a Table of Revisions; and/or quarterly Provider newsletters. Provider bulletins that are state-specific may override the policies and procedures in this manual. For material changes, Missouri Care will send a formal notice in accordance with the terms of the Provider Contract.

Missouri Care provides additional information online via the Quick Reference Guide. The Quick Reference Guide is a document that lists important addresses, phone and fax numbers, and authorization requirements. The Missouri Care Quick Reference Guide is available on the website at www.wellcare.com/Missouri/Providers/Medicaid.

Missouri Care’s Medicaid Managed Care Plans
Missouri Care is a managed care organization contracted with the MO HealthNet Division (MHD), which offers products to MO HealthNet participants. These products are offered in select markets to allow flexibility and offer a distinct set of benefits to fit Member needs in each area.

Missouri Care serves both adults and children eligible to participate in the MO HealthNet program. This plan offers Members more benefits and coverage than traditional Medicaid, at no additional cost. Members may choose their Primary Care Provider (PCP) from a network of participating Providers, including family doctors, pediatricians and internists. Missouri Care Members are not required to get a referral from their PCP before requesting care from a Provider.
## Covered Services

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<th>Adults</th>
<th>Pregnant Women</th>
<th>Children</th>
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<td>Ambulance – Emergency</td>
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**Transportation Services**

Missouri Care will provide non-emergent transportation for Covered Services requested by the Member or someone on behalf of the Member. At the time of transport, the Member must be eligible with Missouri Care with an eligibility code that includes the transportation benefit. Transportation services are not covered for managed care Members with ME Codes 08, 52, 57, 64, 73-75, and 97. Non-emergent transportation services include:

- Transportation to WIC appointments, childbirth classes, breast-feeding classes or similar classes
- Transportation allowing parents to visit a hospitalized child
- Transportation to a pharmacy to pick up prescriptions after a doctor appointment
- Transportation to a methadone clinic
- Transportation to Weight Watchers® and/or to Curves Complete® weight loss programs
- Transportation allowing parents to participate in family therapy at a behavioral health inpatient or residential facility

MTM will schedule the mode of transportation that best meets the Member’s needs. Providers should contact MTM at 1-800-695-5791 as soon as they have an appointment to verify eligibility and make transportation arrangements. Members or other responsible parties should contact Missouri Care at 1-800-322-6027 and follow the prompts related to transportation services. If possible, all requests for transportation should be made at least 3 days before the scheduled appointment.

**Expanded Benefits**

- **Missouri Care** knows how important it is for kids to have a safe place to go after school or to join a club to help them build character. We support this by covering the yearly membership cost for your choice of one of the following programs in your area:
  - **Boy Scouts of America** – The Boy Scouts help build character, train boys to be better citizens and develop personal fitness.
  - **Girl Scouts** – The Girl Scouts build girls of courage, confidence and character who make the world a better place.
  - **4-H** – Kids in 4-H do well in schools and sciences and are committed to improving their communities.
  - **Boys & Girls Clubs of America** – The Boys & Girls Club is a safe place to learn and grow – all while having fun.

- **Diabetes Camp** – One of the best experiences for a child with diabetes. Kids can learn self-confidence while being with other kids who have diabetes. Best of all, they have a great time.

- **Vision Camp** – For kids ages 8–14 years who have vision issues. The day camp lets kids try a number of typical outdoor camp activities. Camp helps kids be independent. It also teaches social skills that help them be successful adults.

- **Art Therapy (2/1/2018)** – Members undergoing cancer treatment, suffering from emotional abuse and post-traumatic stress disorders (PTSD), or diagnosed with autism receive art therapy.

- **Caregiver Influenza Vaccine** – Influenza vaccine for caregivers of Missouri Care children who live in the same household.

- **Caregiver Pertussis (Whooping Cough) Vaccine** – Pertussis vaccine for the entire household (regardless of enrollment with Missouri Care) of members who are pregnant and for caregivers of Missouri Care newborns.

- **Equine Therapy (2/1/2018)** – Members diagnosed with autism receive ten horse-riding sessions per year.

- **Hypoallergenic Bedding** – Hypoallergenic Bedding for qualified members. Member must have a diagnosis of asthma with the qualifying trigger of dust mites, and must complete an Asthma Action Plan.

- **Concierge/Welcome Room** – Provides support for medical and non-medical needs such as application assistance, accessing telehealth services, transportation assistance,
community support needs. Missouri Care plans to open Welcome Rooms in Springfield, Cape Girardeau, and St. Joseph.

- **HiSET** – HiSET exam for members age 16 and over who are not currently enrolled in high school, not a graduate from an accredited high school, and have not received a high school equivalency (HSE) certificate or diploma. To help ensure testing success, members must complete the required HiSET coursework at an adult testing center.
- **Meals** – Members who recently delivered a baby and are working with a Care Manager may be able to get 10 meals for nutritional support after being discharged from the hospital.
- **Cellphone** – Cellphone to members with high-risk pregnancies engaged in a Care Management Program who do not have a telephone. Cellphone would include unlimited text messaging and programmed numbers for the member’s doctor, care manager, or social worker.
- **Mobile App** – Mobile app for members to access their ID card, find a provider and receive alerts when it is time for routine checkups. Please refer to section 2.26.1 for a comprehensive overview of this program.
- **Maternity Support Hose and Support Belts** – Maternity support hose and support belts are available to all pregnant women. No prior authorization is required.
- **Childbirth and Breast-feeding Classes** – Members can attend childbirth and breast-feeding education classes as a benefit to the Member.
- **Breast Pumps** – New moms are eligible for a breast pump, with prior approval.
- **Diabetic Foot Care** – Includes routine trimming of nails, corns and calluses for adult Members with diabetes.
- **Peak Flow Meters** – Includes peak flow meters to asthmatic Members without prior authorization.
- **Enhanced Transportation Service** – Includes transportation to pharmacy trips directly after a medical appointment. Includes transportation to WIC appointments, Child birthing, breast-feeding, or similar classes, and transportation for parents visiting hospitalized child. Transportation to methadone clinic, behavioral health inpatient, or residential facility for parents to participate in family therapy. It also includes transportation to weight loss programs like Weight Watchers® and Curves Complete®.
- **Nurses for Newborns** – Members receive visits from a nurse as needed to support medical and social needs during and after pregnancy (only offered in St. Louis City and Jefferson counties)
- **Maternity Program** – This program will provide the availability of an OB nurse 24 hours a day, seven days a week to provide support, 17P home administration, weekly assessments, education and high risk pregnancy monitoring.
- **Member Incentive Program** – Healthy Rewards recognizes Members for taking small steps that help them live a healthy life. By doing things like completing a Health Risk Assessment form and having certain health checkups, Members earn rewards.
- **Weight Watchers®** – Offers a 6-month membership benefit for qualified Medicaid Members. The goal of the program is to support healthy lifestyles and improve health outcomes.
- **Curves Complete®** – Offers a 3-month membership benefit for qualified Medicaid Members. The goal of the program is to support healthy lifestyles and improve health outcomes.
Non-Covered Services
- Condoms and family planning devices or supplies available as non-prescribed, over-the-counter products
- Reversal of a sterilization procedure
- Abortions for the purpose of family planning should not be reported as such (Abortions are covered through Medicaid FFS)
- Hysterectomies for the purpose of family planning
- Procreative management, such as tubal reversal, artificial insemination
- All services outside the United States and its territories are not covered

Provider Services
The Provider Relations Department is responsible for the field service and ongoing education and training of Missouri Care’s Provider network. Each Provider representative has a thorough understanding of Missouri Care’s operations and is well versed in the MO HealthNet managed care program. The Provider Relations representatives serve as Provider advocates and work, as needed, to assure that you receive necessary assistance and maintain satisfaction with Missouri Care.

To contact your local Provider Relations representative please call Missouri Care Provider Services at 1-800-322-6027.

Key reasons to contact your Provider Relations representative include:
- To notify Missouri Care of any change to your practice – (i.e., practice TIN, name, phone number, fax number, address, addition or termination of Providers, or change in patient acceptance)
- To schedule an in-service for new staff
- To conduct ongoing education for existing staff
- To obtain clarification on policies and procedures
- To obtain clarification about your Provider Contract
- To request collateral materials such as a Provider Manual, HEDIS® billing guide, and other documents
- To obtain information about the key features and benefits of Missouri Care’s secure provider portal and web capabilities
- To obtain responses to Membership list questions

Providers may contact the appropriate departments for other needs such as eligibility verification, claim inquiries, prior authorizations, and Care Management referrals at Missouri Care by referring to the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

Interactive Voice Response (IVR) System
New IVR system
- New technology to expedite Provider verification and authentication within the IVR
- Provider/Member account information is sent directly to the agent’s desktop from the IVR validation process, so Providers do not have to re-enter information
- Full speech capability, allowing Providers to speak their information or use the touch-tone keypad
Self-Service Features
- Ability to receive Member co-pay benefits
- Ability to receive Member eligibility information
- Ability to request authorization and/or status information
- Unlimited claims information on full or partial payments
- Receive status for multiple lines of claim denials
- Automatic routing to the PCS claims adjustment team to dispute a denied claim
- Rejected claims information is now available through self-service

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

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

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

Website Resources
Missouri Care’s website, www.wellcare.com/Missouri/Providers, offers a variety of tools to assist Providers and their staff.

Available resources include:
- Provider Manual;
- Quick Reference Guide;
- Clinical Practice Guidelines;
- Clinical Coverage Guidelines;
- Provider Lookup (directory);
- Authorization Lookup tool;
- Training materials and guides or job aids;
- Newsletters;
- Member rights and responsibilities;
- Privacy statement and notice of privacy practices; and
- Additional forms and documents.
Secure Provider Portal: Key Features and Benefits of Registering
WellCare’s secure online Provider portal offers immediate access to what Providers need most. All participating Providers who create an account and are assigned the appropriate role/permissions can use the following features:

- **Claims Submission, Status, Appeal, Dispute** – Submit a claim, check status, appeal or dispute claims, and download reports;
- **Member Eligibility, Co-Pay Information and More** – Verify member eligibility, and view co-pays, benefit information, demographic information, care gaps, health conditions, visit history and more;
- **Authorization Requests** – Submit authorization requests, attach clinical documentation, check authorization status and submit appeals. Providers may also print and/or save copies of the authorization;
- **Pharmacy Services and Utilization** – View and download a copy of WellCare’s preferred drug list (PDL), access pharmacy utilization reports, and obtain information about WellCare pharmacy services;
- **Visit Checklist/Appointment Agenda** – Download and print a checklist for member appointments, then submit online to get credit for Partnership for Quality (P4Q);
- **Secure Inbox** – View the latest announcements for providers and receive important messages from WellCare.

Provider Registration Advantage
The secure Provider portal allows Providers to have one username and password, and be affiliated with multiple Providers/offices. Administrators can easily manage users and permissions. Once registered for WellCare’s portal, Providers should retain their username and password information for future reference.

How to Register
To create an account, please refer to the Provider Resource Guide on WellCare’s website at www.wellcare.com/Missouri/Providers/Medicaid. For more information about WellCare’s web capabilities, please call Provider Services or contact Provider Relations to schedule a website in-service.

Additional Resources
**Parents as Teachers**
Parents as Teachers (PAT) is a home-school-community partnership that supports parents in their role as their child’s first and most influential teachers. The PAT program is administered at the local level by the public school districts in the State of Missouri. While not a Medicaid Covered Benefit, every family who is expecting a child or has a child under the age of kindergarten entry is eligible for PAT.

PAT includes personal visits from certified parent educators, group meetings, developmental screenings, and connections with other community resources. Families interested in PAT may contact their local school district directly. PAT also accepts referrals from medical Providers. Additional information about PAT is available at the Department of Elementary and Secondary Education website at dese.mo.gov or the National Center for Parents as Teachers® at www.parentsasteachers.org.
The Provider Resource Guide contains information about the secure online provider portal, Member eligibility, authorizations, filing paper and electronic claims, appeals and more. The Resource Guide is available on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

Another valuable resource is the Quick Reference Guide, which contains important addresses, phone/fax numbers and authorization requirements. The Quick Reference Guide is available on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Guidelines

Overview
This section is an overview of guidelines for which all participating Missouri Care Medicaid Managed Care Providers are accountable. Please refer to the Provider Contract contact your Provider Relations representative for clarification of any of the following.

Participating Missouri Care 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 Missouri Care in its efforts to monitor compliance with its Medicaid contract(s) and/or MO HealthNet Division (MHD) rules and regulations, and assist Missouri Care in complying with corrective action plans necessary for Missouri Care to comply with such rules and regulations;
- Retain all agreements, books, documents, papers and medical records related to the provision of services to Missouri Care Members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of healthcare [42 C.F.R. § 422.504(a)(3)(iii).;
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) should provide direct Member care within the scope or practice established by the rules and regulations of MHD and Missouri Care guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician extender title (examples: MD, DO, ARNP, PA) to Members and to other health care professionals;
- Honor at all times any Member request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any Member in need of health care services;
- Maintain the confidentiality of Member information and records;
- Allow Missouri Care to use Provider performance data for quality improvement activities;
- Respond promptly to Missouri Care’s request(s) for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all Missouri Care’s policies governing content and confidentiality of medical records as outlined in Section 3: Quality Improvement and Section 8: Compliance;
- Ensure that:
To the extent, the Provider maintains written agreements with employed physicians and other health care practitioners, such agreements contain similar provisions to the Contract.

- 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 Missouri Care, 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 Missouri Care Medicaid Members and Medicaid Members who are not Missouri Care Members. Ensure that the hours of operation offered to Missouri Care Members are no less than those offered to patients with commercial insurance;
- Not deny, limit or condition the furnishing of treatment to any Missouri Care Member on the basis of any factor that is related to health status, including, but not limited to, the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of healthcare; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability;
- Freely communicate with and advise Members regarding the diagnosis of the Member’s condition and advocate on Member’s behalf for Member’s health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
- Identify Members 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 Missouri Care-sponsored or community-based programs; and
- Document the referral to Missouri Care-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. Missouri Care is not financially responsible for non-Covered Benefits or for services rendered to ineligible recipients. Certain Covered Benefits, such as non-emergency transportation, are coordinated by Missouri Care although administered outside of the managed care program.

Excluded services are defined as those services that are not considered Covered Benefits under the MO HealthNet program, and for which Missouri Care is not financially responsible. Providers are required to determine eligibility and Covered Services prior to rendering services.

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

**Provider Identifiers**
All participating Providers are required to have a National Provider Identifier (NPI). For more information on NPI requirements, refer to *Section 5: Claims*.

**Living Will and Advance Directive**
Members have the right to control decisions related to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Living will and advance directive rights may differ between states. Providers must comply with the advance directive requirements for hospitals, nursing facilities, Providers of home and healthcare hospices, and HMOs specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d).

Each Missouri Care Member (age 18 years or older and of sound mind) should receive information regarding a living will and advance directives. This allows them to designate another person to make a healthcare decision should they become mentally or physically unable to do so. Missouri Care provides information on advance directives in the Member Manual.

Information regarding a living will and advance directives should be made available in Provider offices and discussed with the Members. Completed forms should be documented and filed in Members’ medical records.

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

The above shall not be construed to prohibit the application of any Missouri law, which allows for an objection on the basis of conscience for any Provider or agent of such Provider.

**Notification of Practice Information Changes**

Missouri Care relies on the Provider network to advise of changes in order to keep the Provider information current. Out-of-date Provider information causes the Provider Directory to be incorrect and can result in claim processing delays, claim denials or incorrect payments when the system does not match the information submitted on claims.

Prior written notice of the following changes is required:

<table>
<thead>
<tr>
<th>Group Name or Affiliation</th>
<th>Telephone or fax number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panel Status</td>
<td>Tax Identification Number</td>
</tr>
<tr>
<td>Physical or Billing address</td>
<td>Billing Address</td>
</tr>
<tr>
<td>1099 Mailing Address</td>
<td>Fax Number</td>
</tr>
<tr>
<td>Office Hours</td>
<td>Age Limitation</td>
</tr>
<tr>
<td>Languages Spoken</td>
<td>Terminations</td>
</tr>
</tbody>
</table>
Practice information updates are processed within 30 days of receipt. Please submit changes in writing to Missouri Care as far in advance of the change as possible. We require 90 days’ prior written notice of Provider terminations.

Please see the Provider newsletters for fax number, email and physical address that should be used to submit changes. Providers may also submit the update requests directly to their assigned Provider Operations Coordinator or Provider Relations representative.

**Enrollment of New Professional Providers**
Missouri Care participates with the Council for Affordable Quality Healthcare’s® (CAQH’s) Universal Credentialing Data Source initiative and uses CAQH data in the initial credentialing process for new physicians and other healthcare Providers wishing to join the Missouri Care network.

To begin the enrollment process, please submit a written request (letter or email) to add a new Provider, the related group practice name and tax ID, and the new Provider’s CAQH number. You may also submit these requests on the Provider Profile Form available from your Provider Relations representative.

The Provider’s CAQH information must be complete and current. We will not be able use the CAQH information unless it is complete, up-to-date, and has been attested to within the last three months. Key CAQH data elements and documentation include: license, insurance, work history, board certifications, DEA certificate, hospital privileges, and a current W9.

The Provider enrollment process, including credentialing, is completed within 60 days from the date of request as long as all required information is available. If the needed CAQH information is not current, we will advise the requester and will be unable to begin the 60-day enrollment and credentialing process until the deficiencies are addressed.

Providers will be notified in writing of their participation effective date. Services provided in advance of the participation effective date require prior authorization. If prior authorization is not obtained, these services will not be payable.

In order to maintain the integrity of provider directory data, Missouri Care may rely on information independently verified by a third party, and may take appropriate actions to remove inaccurate provider data from the directory.

**Provider Termination**
In addition to the Provider termination information included in the Provider Contract, Providers must adhere to the following terms:

- Unless a different notice period is expressly stated in the Contract, a contracted Provider must give at least 90 days’ prior written notice to Missouri Care before terminating a relationship with Missouri Care “without cause,” unless otherwise agreed to in writing. This ensures that adequate notice may be given to Missouri Care Members regarding the Provider’s participation status with Missouri Care.
- All Provider termination time frames and notices shall be provided in accordance with the terms of the Provider Contract.
• Members in active treatment may continue care when such care is Medically Necessary, through the completion of treatment of a condition for which the Member was receiving at the time of the termination or until the Member selects another treating Provider, not to exceed 90 days after the Provider termination.

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

**Note:** Missouri Care will notify, in writing, all appropriate agencies and/or Members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary Provider within the service area except under the following circumstances:
- A Provider becomes physically unable to care for Members due to illness
- The Provider is deceased
- The Provider moves outside of the service area and fails to notify Missouri Care
- The Provider fails credentialing

**Out-of-Area Member Transfers**
Providers should assist Missouri Care in arranging and accepting the transfer of Members receiving care out of the service area if the transfer is considered medically acceptable by the Missouri Care Provider and the out-of-network attending physician/provider.

**Members with Special Healthcare Needs**
Individuals with Special Healthcare Needs (ISHCN) include Members with the following conditions:
- Intellectual disabilities or related conditions
- Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes
- Children and adults with certain environmental risk factors such as homelessness or family problems that led to the need for placement in foster care
- Related populations eligible for SSI
- Individuals who, without services such as private duty nursing, home health, durable medical equipment/supplies, and care management may require hospitalization or institutionalization. The following groups of individuals are at high risk of having a special health care need:
  - Individuals with autism spectrum disorder;
  - Individuals in foster care or other out-of-home placement;
  - Individuals receiving foster care or adoption subsidy; and
  - Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the State agency in terms of either program participant or special healthcare needs.

The following is a summary of responsibilities specific to Providers who render services to Missouri Care Members who have been identified with special healthcare needs:
• Assess Members and develop plans of care for those Members determined to need courses of treatment or regular care,
• Coordinate treatment plans with Members, family and/or specialists caring for Members,
• Plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards,
• Allow Members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the Members’ conditions or needs,
• Coordinate with Missouri Care, if appropriate, to ensure that each Member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished,
• Coordinate services with other third-party organizations to prevent duplication of services and share results on identification and assessment of the Member’s needs, and
• Ensure the Member’s privacy is protected as appropriate during the coordination process.

For more information on Utilization Management for ISHCN, refer to Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM).

Access Standards
Providers must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the Member’s needs. Missouri Care shall monitor Providers against these standards to ensure Members can obtain needed health services for specified appointment types within acceptable in-office wait times. Providers not in compliance with these standards will be required to implement corrective actions set forth by Missouri Care.

<table>
<thead>
<tr>
<th>VISIT TYPE</th>
<th>APPOINTMENT TYPE</th>
<th>ACCESS STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Medical - Urgent Care</td>
<td>within 24 hours</td>
</tr>
<tr>
<td>Medical</td>
<td>Medical - Sick</td>
<td>within 7 calendar days or 5 business days (whichever is earlier)</td>
</tr>
<tr>
<td>Medical</td>
<td>Medical - Routine</td>
<td>within 30 calendar days</td>
</tr>
<tr>
<td>Medical</td>
<td>Follow-up to hospital discharge</td>
<td>within 7 calendar days from discharge date</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>BH - Non-Life Threatening Emergency</td>
<td>within 6 hours</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>BH - Urgent</td>
<td>within 24 hours</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>BH – Routine with Symptoms</td>
<td>within 7 calendar days or 5 business days (whichever is earlier)</td>
</tr>
</tbody>
</table>
The average wait times for appointments should not exceed one hour from scheduled appointment times. This includes time spent both in the lobby and in the room before Provider examination.

**Responsibilities of Primary Care Physicians (PCP)**
The following is a summary of responsibilities specific to PCPs who render services to Missouri Care Members. These are intended to supplement the terms of the Contract, not replace them:

- Coordinate, monitor and supervise the delivery of primary care services to each Member;
- See Members for an initial office visit and assessment within the first 90 days of enrollment in Missouri Care;
- Coordinate, monitor and supervise the delivery of Medically Necessary primary and preventive care services to each Member, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for Members under the age of 21;
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants, and Children (WIC) program for nutritional assistance;
- Maintain continuity of each Member’s healthcare;
- Make referrals for specialty care and other Medically Necessary services to both in-network and out-of-network providers;
- Work with health plan care managers in developing plans of care for Members receiving care management services;
- Conduct a behavioral health screen to determine whether the Member needs behavioral health services;
- Maintain a comprehensive, current medical record for the Member, including documentation of all services provided to the Member by the PCP, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens, etc.;
• Provide or arrange for coverage of services, consultation or approval for referrals 24 hours a day, seven days a week. To ensure accessibility and availability, PCPs must provide one of the following:
  o A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP;
  o An answering system with the option to page the physician for a return call within a maximum of 20 minutes if urgent or one hour if non-emergent; or
  o An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes;
• Assure Members are aware of the availability of public transportation where available;
• Provide access to Missouri Care 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 Healthcare Effectiveness Data and Information Set (HEDIS®) service. For more information on encounters, refer to Section 5: Claims;
• Ensure Members use network Providers. If unable to locate a participating Missouri Care Medicaid Provider for services required, contact Provider Services for assistance. Refer to the Quick Reference Guide which may be found on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid; and
• Comply with and participate in corrective action and performance improvement plan(s).

Continuity and Coordination of Care between PCPs and Specialists
Continuity and coordination of care between Primary Care Providers and specialists is an important aspect in the delivery of quality healthcare. Care provided by specialists can affect an individual’s health.

We strongly encourage open communication between PCPs and specialists. If a Member’s medical or behavioral condition changes, Missouri Care expects that both PCPs and specialists will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers.

Communication with the PCP should occur more frequently if clinically indicated. Missouri Care expects PCPs and specialists to respond to routine coordination requests within two business days and one calendar day for urgent requests.

Continuity and Coordination of Care between PCPs and FQHC/RHC Providers
Continuity and coordination of care between Primary Care Providers and FQHC and RHC Providers is an important aspect in the delivery of quality healthcare. Care provided by FQHC and RHC Providers can affect an individual’s health.

We strongly encourage open communication between PCPs and FQHC and RHC Providers. If a Member’s medical or behavioral condition changes, Missouri Care expects that both PCPs and FQHC and RHC 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.
Communication with the PCP should occur more frequently if clinically indicated. Missouri Care expects PCPs, FQHC and RHC Providers to respond to routine coordination requests within two business days and one calendar day for urgent requests.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**

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

- Conducting and documenting well-child visits (screenings) using the state agency’s *HCY/EPSDT Screening Form* found on the Internet at: [manuals.momed.com](http://manuals.momed.com). Healthy Children and Youth Screening Guide forms from newborn to 20 years of age can be found under *Healthy Children and Youth Screening [HCY Screening]* at this site ([Direct Link](http://manuals.momed.com/manuals/presentation/forms.jsp)).
- Referring the Member to an out-of-network provider for treatment if the service is not available within Missouri Care’s network.
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. **Note:** Refer to Section 3: Quality Improvement, to view MO HealthNet’s “Immunizations Record” for Members.
- Providing vaccinations in conjunction with EPSDT/well-child visits.
- Providers shall enroll and obtain vaccines through the Missouri Department of Health and Senior Services Vaccines for Children (VFC) Program or any such vaccine supply program as designated by the state agency. Any time a Member receives immunizations from a local public health agency, or at a Special Supplemental Nutrition Program for Women, Infants and Children (WIC) site, the health plan shall reimburse only the cost for administration at the current MO HealthNet program rates in effect at the time of the service, unless otherwise negotiated. Members with ME codes 73 through 75 and 97 are not eligible to receive vaccines through the VFC Program.
- Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits.
- Monitoring, tracking and following up with Members:
  - Who have not had a health assessment screening
  - Who miss appointments, to assist them in obtaining an appointment
- Ensuring Members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with Members to ensure they receive the necessary medical services.
- Assisting Members with transition to other appropriate care for children who age-out of EPSDT services.

The health plan shall reimburse governmental public health agencies for the cost of both administration and vaccines not available through the VFC program or vaccine supply program, as designated by the state agency when the vaccine is deemed Medically Necessary.

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 Missouri Care or are not in compliance with the EPSDT Program.

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

For more information on EPSDT Covered Services, refer to Section 1: Overview. For additional information regarding EPSDT requirements, see Section 3: Quality Improvement.

Note: Refer to Section 3: Quality Improvement, to view MO HealthNet's “Health Screen & Lead Poison Assessment Record” for Members.

Primary Care Offices
PCPs provide comprehensive primary care services to Missouri Care Members. Primary care offices participating in Missouri Care’s Provider network have access to the following services: Support of the Provider Relations, Provider Services, Clinical Services and Marketing and Sales Departments; as well as the tools and resources available on Missouri Care’s website at www.wellcare.com/missouri; and

- Information on Missouri Care network Providers for the purposes of referral management and discharge planning.

Panel Threshold
Missouri Care requires that all in-network Providers give a report detailing the number of Members they will accept as patients (in the case of PCPs) or limitations to the number of referrals they will accept (in the case of non-PCPs). This information is to be reported within 30 days of initial contracting and any time thereafter when panel status changes. In addition, Missouri Care requires that all Providers report to the Provider Relations Department as soon as possible when they reach 85 percent of their panel capacity. The Provider Relations Department shall regularly review these reports to identify any changes that may require additional network recruiting.

Closing of Physician Panel
A PCP can close their panel to Missouri Care Members only if they close their panel to all payers/patients. When requesting closure of your panel to new and/or transferring Missouri Care Members, PCPs must:

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

Covering Physicians/Providers
In the event that participating Providers are temporarily unavailable to provide care or referral services to Missouri Care Members, Providers should make arrangements with another Missouri Care-contracted Medicaid (participating) and credentialed Provider to provide services on their behalf, unless there is an emergency.

Covering physicians should be credentialed by Missouri Care, and are required to sign an agreement accepting the negotiated rate and agreeing to not balance bill Missouri Care Members. For additional information, please refer to Section 6: Credentialing.
In non-emergency cases, should you have a covering physician/Provider who is not contracted and credentialed with Missouri Care, contact Missouri Care for approval. For more information, refer to the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

Termination of a Member
A Provider may not seek or request to terminate his/her relationship with a Member, or transfer a Member to another Provider of care, based upon the Member’s medical condition, amount or variety of care required, or the cost of Covered Services required by Missouri Care’s Member.

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

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

The Provider should complete a PCP Request for Transfer of a Member Form, attach supporting documentation, and fax the form to Missouri Care’s Provider Relations Department.

Smoking Cessation
PCPs should direct Members who smoke and wish to quit smoking to call Missouri Care’s Provider Services and ask to be directed to the Care Management Department. A care manager will educate the Member on state, national and community resources that offer assistance, as well as smoking cessation options available to the Member through Missouri Care. Missouri does have a smoking cessation program that includes pharmacological and behavioral health interventions.

Adult Health Screening
An adult health screening should be performed by a physician to assess the health status of all Missouri Care Medicaid Members. The adult Member should receive an appropriate assessment and intervention as indicated, or upon request.

Member Administrative Guidelines

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

All newly enrolled Members will receive a Member Handbook within 10 business days of receiving the notice of enrollment from Missouri Care. Missouri Care will mail all newly enrolled Members a Member Handbook via U.S. Postal Service.

**Enrollment**

Members must apply for, and maintain eligibility for, medical assistance through their local Family Support Division (FSD) office. Once determined eligible to participate in the MO HealthNet program, Members may elect Missouri Care as their healthcare plan. Missouri Care must obey laws that protect from discrimination or unfair treatment. Missouri Care does not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin.

Upon assignment to Missouri Care, Members are provided the following information:

- 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; and
- Grievance and disenrollment procedures.

**Member Identification Cards**

Member identification (ID) cards are intended to identify Missouri Care Members, the type of plan they have and to facilitate their interactions with healthcare Providers. Information found on the Member ID card may include the Member’s name, ID number, plan type, PCP’s name and telephone number, health plan contact information and claims filing address. Possession of the Member ID card does not guarantee eligibility or coverage. Providers are responsible for determining the current eligibility of the cardholder.

**Eligibility Verification**

A Member’s eligibility status can change at any time. Therefore, all Providers shall request and copy a Member’s ID card, along with additional proof of ID, such as photo identification and file them in the patient’s medical record. In addition, Providers should access the secure portal of Missouri Care’s website at [www.missouricare.com/login/provider](http://www.missouricare.com/login/provider) to obtain a Member’s current assigned PCP.

Providers must perform the following to verify eligibility:

- Access the secure, online portal of Missouri Care’s website at [www.missouricare.com/login/provider](http://www.missouricare.com/login/provider);
- Access the MO HealthNet portal at [www.emomed.com](http://www.emomed.com);
- Access Missouri Care’s Interactive Voice Response (IVR) system; and/or
- Contact Provider Services

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See your contract for additional details.
Member Rights and Responsibilities
Missouri Care Members, both adults and children, have specific rights and responsibilities. These are included in the Member Handbook.

Member Rights as a MO HealthNet Managed Care Health Plan Member
Whether or not a Member receives a service from an in-network Provider or an out-of-network provider, Members have the right to:

- Be treated with respect and dignity
- Receive needed medical services
- Privacy and confidentiality subject to state and federal laws
- Select a PCP of their choice from within Missouri Care’s network
- Refuse treatment
- Receive information about their healthcare and treatment options
- Participate with practitioners in decision making about their healthcare
- Have access to their medical records and to request changes, if necessary
- Have someone act on their behalf if they are unable to do so
- Get information on Missouri Care’s Physician Incentive Plan, if any, by calling 1-800-322-6027
- Be free of restraint or seclusion from a Provider who wants to:
  - Make them do something they should not do
  - Punish them
  - Get back at them
  - Make things easier for the Provider
- Be free to exercise these rights without retaliation
- Receive one copy of their medical records once a year at no cost to them

Missouri Care Members Have Additional Rights to:
- Voice grievances or appeals about Missouri Care or about the care the Member received from a Provider
- Make recommendations regarding Missouri Care’s policy regarding Member rights and responsibilities
- Receive information about Missouri Care, its services, its practitioners and Providers and their rights and responsibilities
- Have an open discussion with Providers about appropriate or Medically Necessary treatment options regardless of cost or benefit coverage

Members Have a Responsibility to:
- Read and follow their handbook
- Show their Missouri Care ID card and MO HealthNet red or white card to each healthcare Provider before they get medical services
- Know the name of their PCP and be sure the correct one is on their ID card
- Keep address and phone number current with Missouri Care and MO HealthNet
- Get approval from their PCP before they receive services from any other Provider unless it is an emergency. There are exceptions, such as family planning. Call Member Services at 1-800-322-6027 with questions.
- Make appointments ahead of time for all PCP visits or transportation
• Be on time for appointments or cancel the day before their appointment
• Give their PCP their past health information. Their PCP needs to see immunization records for Members up to age 21.
• Give information that Missouri Care needs
• Give information that Providers need to deliver care
• Follow plans and instructions for care that they have agreed to with their Provider
• Understand their health problems
• Help set agreed upon treatment goals with their Provider
• Tell Missouri Care and the Family Support Division Information Center if there are changes or family has changes that will change eligibility
• Tell Missouri Care and the Family Support Division Information Center if they have an accident at work, car accident, or are involved in a personal injury or malpractice lawsuit
• Give a copy of living will or advance directives to PCP to include with their medical records

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

Changing Primary Care Physicians
Members may change their PCP selection at any time by calling Member Services. The requested change will be effective the first day of the following month of the request if the request is received after the 10th day of the current month.

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

Interpreters and Sign Language Services
Interpreters and sign language services are available through Missouri Care’s Member Services for Members who are hard of hearing or don’t speak English. Multilingual and TTY services also are available. PCPs should coordinate these services for Missouri Care Members and contact Provider Services if assistance is needed. Please refer to the Quick Reference Guide for the Provider Services telephone numbers on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.
Section 3: Quality Improvement

Overview
The purpose of Missouri Care’s Quality Improvement Program (QI Program) is to:
- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare and services, as well as provide the essential infrastructure, resources, and processes to impact desired health outcomes.
- Identify and implement strategies to improve the quality, appropriateness and accessibility of healthcare provided to members
- Facilitate organization wide integration of quality management principles

Goals are established to support the purpose of the QI Program. All goals are reviewed annually and revised as needed. The QI Program goals are primarily identified through:
- Ongoing activities that monitor care and service delivery
- Issues identified by tracking and trending data over time
- Issues/outcomes identified in the previous year’s QI Program Evaluation
- Internal process reviews
- Accreditation, regulatory and contractual standards

The Quality Improvement Program objectives are to:
- Facilitate the integration, support and commitment to continuous quality improvement throughout the Plan for sustained improvements.
- Encourage and evaluate compliance to policies and procedures that standardize approaches to the completion of activities that reflect key program components.
- Develop and maintain a process through which clinical and operational performance is continuously measured, opportunities for improvement identified, meaningful interventions are initiated as appropriate and the results of actions taken to improve outcomes are evaluated.
- Select and conduct meaningful and relevant (high-volume, high-risk and/or problem prone) population-specific quality improvement initiatives that achieve, through ongoing measurement and intervention, sustained and significant improvement in aspects of clinical care and non-clinical services.
- Ensure availability of and access to qualified providers, adhering to established standards for credentialing and re-credentialing of network practitioners and providers.
- Adopt and disseminate evidence-based guidelines, thereby promoting the delivery of safe clinical practice.
- Facilitate integration of services to promote continuity and coordination of care, whether resulting from a change in setting or a transition of care between physicians, inclusive of both medical and behavioral health care delivery situations.
- Promote a supportive environment that assists associates and providers to render culturally competent medical and behavioral healthcare and/or services, thereby promoting compliance with the WellCare Corporate Cultural Competency Plan.
- Encourage member participation in Plan programs and services through the dissemination of information that considers language and readability levels.
- Maintain established safeguards for Member privacy, including confidentiality of Member health information in accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations adopted thereunder (collectively, HIPAA).
- Engage members in managing, maintaining, and/or improving their current health status through preventive/wellness activities, disease management, care management and other chronic care initiatives.
- Maintain a process for Members, Providers, various healthcare associations and community agencies to receive updates, and offer suggestions, concerns, and recommendation regarding the QI Program and activities.
- Ensure all aspects of the QI Program and activities are in compliance with contractual, state, federal and accreditation standards.
- Collaborate with various internal stakeholders to ensure the Plan’s information system supports the collection, tracking, analysis, reporting and historical record keeping of relevant QI Program related data.
- Establish standards and conduct continuous, comprehensive oversight of all delegated entities.
- Establish standards and objectives for serving Members with complex health needs.
- Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Health Plans Study (CAHPS®) results that evidence improvements in Plan initiatives to improve Member experience, satisfaction, health, and wellness.
- Conduct population-specific quality improvement (QI) initiatives that achieve, through ongoing measurement and intervention, sustained and significant improvement in aspects of clinical care and non-clinical services.
- Annually, specific objectives to promote realization of select goals are identified and recorded in the Work Plan document.

The scope of the QI Program is comprehensive, systematic and continuous. It applies to all Member demographic groups, care settings and types of services afforded to Medicaid (and State Children’s Health Insurance Program (SCHIP) membership. The QI Program addresses the quality of clinical care and non-clinical aspects of service. Key areas of focus include objective and systematic measures that include, but are not limited to:

- Utilization management
- Disease and care management
- Coordination/continuity of care
- Practitioner availability and accessibility
- Preventive and clinical health
- Quality of care and service utilization
- Cultural competency
- Credentialing
- Patient safety
- Appeals/grievances/complaints
- Member experience
- Provider experience
- Components of operational service
- Contractual, regulatory and/or accreditation reporting requirements
The Plan’s Board of Directors (the Board) is the governing body of the Plan and responsible for the general oversight and strategic direction of the QI Program. The Board has ultimate accountability and responsibility for the quality of healthcare and other services rendered to Plan members. The Board has delegated the following responsibilities:

- Overall oversight of the day-to-day operations of the QI Program to the Director of Quality Improvement, with support from Missouri Care’s Sr. Medical Director
- Authority to approve specific Plan QI activities (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate) to the Quality Improvement Committee (QIC); and
- Implementation of the Plan’s Utilization Management Program (the UM Program) to the Utilization Management Medical Advisory Committee (UMAC), a sub-committee of the QIC.

Missouri Care is continuously assessing data and information to improve the level of care provided to their members. Some of the programs/initiatives in place include, but are not limited to:

- Access/Availability Monitoring
- Appeals/Concerns/Complaints/Grievances
- Member Experience
- Provider Experience
- Behavioral Health Services
- Utilization Management
- Care and Disease Management
- Special Needs
- Patient Safety
- Continuity and Coordination of Care
- Quality Improvement Projects
- Clinical Indicators and Initiatives
- Credentialing and Peer Review
- Preventive and Clinical Health Guidelines
- Medical Record Review
- Delegation
- Cultural Competency

**Provider Participation in the Quality Improvement Program**

Network Providers are contractually required to cooperate with QI activities. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) assessments, and feedback/input via satisfaction surveys, grievances, and calls to Provider Services. Missouri Care seeks input from and works with Members, Providers, and community resources and agencies to actively improve the quality of care provided to Members. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

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

**Member Satisfaction**
On an annual basis, Missouri Care conducts a Member satisfaction survey of a representative sample of Members. Satisfaction with services, quality, and access is evaluated. The results are compared to Missouri Care’s performance goals, and improvement action plans are developed to address any areas not meeting the standard.

**Health Screen & Lead Poison Assessment**
MO HealthNet provides the following Health Screen & Lead Poison Assessment Record for Members:

<table>
<thead>
<tr>
<th>Age</th>
<th>Date of Health Screen</th>
<th>Date of Lead Poison Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By 1 month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2–3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4–5 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6–8 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9–11 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–14 months</td>
<td></td>
<td>Your child needs a Blood Lead Level at 12 and 24 months.</td>
</tr>
<tr>
<td>15–17 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–23 months</td>
<td></td>
<td>Your child needs a Blood Lead Level each year until age 6 if in a high-risk area.</td>
</tr>
<tr>
<td>24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6–7 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8–9 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10–11 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–13 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14–15 years</td>
<td></td>
<td>A Blood Lead Level is recommended for women of childbearing age.</td>
</tr>
<tr>
<td>16–17 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–19 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The MO HealthNet online Provider Manual references the Childhood Immunization Schedule on the Department of Health & Senior Services’ website at health.mo.gov (Direct Link: health.mo.gov/living/wellness/immunizations/professionals.php).
Immunization (Shot) Schedule for Children

MO HealthNet provides Members with the following current, abbreviated CDC immunization schedule. Immunizations (shots) help prevent serious illness. This record will help keep track when your child is immunized. If your child did not get their shots at the age shown, they still need to get that shot. Talk to your PCP about your child’s immunizations (shots). Children must have their immunizations (shots) to enter school.

<table>
<thead>
<tr>
<th>Age</th>
<th>Shot (Immunization)</th>
<th>Date Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>HepB*</td>
<td></td>
</tr>
<tr>
<td>2 months</td>
<td>DTaP, Hib, IPV, PCV, RV, HepB</td>
<td></td>
</tr>
<tr>
<td>4 months</td>
<td>DTaP, Hib, IPV, PCV, RV, HepB*</td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>DTaP, Hib, IPV, PCV, RV, HepB</td>
<td></td>
</tr>
<tr>
<td>12-15 months</td>
<td>Hib, PCV, MMR, Varicella, HepA</td>
<td></td>
</tr>
<tr>
<td>15-18 months</td>
<td>DTaP**</td>
<td></td>
</tr>
<tr>
<td>19-23 months</td>
<td>HepA</td>
<td></td>
</tr>
<tr>
<td>4-6 years</td>
<td>DTaP, IPV, MMR, Varicella</td>
<td></td>
</tr>
<tr>
<td>7-10 years</td>
<td>Tdap, HepB, IPV, MMR, Varicella, HepA</td>
<td></td>
</tr>
<tr>
<td>11-12 years</td>
<td>Tdap, MenACWY (1 dose), HPV (2 doses)***</td>
<td></td>
</tr>
<tr>
<td>11-12 years</td>
<td>HepB, IPV, MMR, Varicella, HepA</td>
<td></td>
</tr>
<tr>
<td>13-18 years</td>
<td>Tdap, MenACWY (1 dose, Booster at 16), HPV, HepB, IPV, MMR, Varicella, HepA</td>
<td></td>
</tr>
<tr>
<td>16-18 years</td>
<td>MenB****</td>
<td></td>
</tr>
<tr>
<td>19-20 years</td>
<td>HPV (3 doses)***** , MMR******, Tdap******, Varicella*****</td>
<td></td>
</tr>
<tr>
<td>Every year</td>
<td>Influenza (after 6 months)</td>
<td></td>
</tr>
</tbody>
</table>

*If the birth dose of HepB is given, the 4-month dose may be omitted.
**Can be given as early as 12 months, if there are 6 months since third dose.
***A 3-shot series is needed for those with weakened immune systems and those age 15 or older.
****Can be given sooner for those that have certain health conditions that would put them at increased risk for serious diseases.
*****Recommended unless your healthcare provider tells you that you do not need it or should not get it.
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 height or length 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 age 2 or older
- Blood pressure apparatus with infant, child and adult cuffs
- Eye charts appropriate to children by age
- Developmental and behavioral screening tools
- Ophthalmoscope and otoscope

**120-day Non-Compliant Report**

Missouri Care will send Providers a monthly Membership list of EPSDT-eligible children who have not had a screening within 120 days of enrolling with Missouri Care. Missouri Care shall provide written notification to its families with eligible children when appropriate well-child visits are due. The health plan shall follow up with families that have failed to access well-child visits after 120 calendar days of when the well-child visit was due. The health plan shall provide to each PCP, on a monthly basis, a list of the eligible children who are not in compliance with the periodicity schedule. The PCP shall contact these Members/Members’ parents or guardians to schedule an appointment.

**Clinical Practice Guidelines (CPGs)**

Missouri Care adopts validated evidence-based CPGs and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede CPGs, 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 CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the Corporate Medical Policy Committee (MPC) and the Market Utilization Management Medical Advisory Committee (UMAC), which reports to the QI Committee. CPGs, to include preventive health guidelines, are on our corporate website at [www.wellcare.com/Missouri/providers/Clinical-Guidelines/CPGs](http://www.wellcare.com/Missouri/providers/Clinical-Guidelines/CPGs).

**HEDIS®**

HEDIS (Healthcare Effectiveness Data and Information Set) consists of a set of performance measures utilized by more than 90 percent of American health plans that compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

**Why HEDIS is Important**

HEDIS ensures health plans are offering quality preventive care and service to Members. It also allows for a true comparison of the performance of health plans by consumers and employers.
Value of HEDIS to you, our Providers
HEDIS can help save you time while also potentially reducing health care costs. By proactively managing patients’ care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care.

HEDIS can also help you:
- Identify noncompliant Members to ensure they receive preventive screenings.
- Understand how you compare with other Missouri Care Providers as well as with the national average.

Value of HEDIS to your patients, our Members
HEDIS ensures that Members will receive optimal preventive and quality care. It gives Members the ability to review and compare plans’ scores, helping them to make informed healthcare choices.

What you can do
- Encourage your patients to schedule preventive exams
- Remind your patients to follow up with ordered tests
- Complete outreach calls to noncompliant Members.

Consumer Assessment of Health Care Providers and Systems (CAHPS®)
CAHPS is a survey that asks patients to report on and evaluate their healthcare experiences. Your patients will be asked to evaluate you on the following topics:
- How often did you listen carefully to your patient?
- How often did you show respect for what your patient had to say?
- How often did you spend enough time with your patient?
- Care coordination between PCP and specialists
- Getting appointments and care quickly
- Ease of getting needed care when seeing specialists

Medical Records
Medical records should be accurate, comprehensive, and reflect all aspects of care for each Member. Records are to be maintained in a secure, timely, legible, current, detailed and organized manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment. Medical records must be signed and dated. Complete medical records shall include, but are not limited to: medical charts, health status screens, prescription files, hospital records, Provider specialist reports, consultant and other healthcare professionals’ findings, appointment records, and other documentation sufficient to disclose the quantity, quality appropriateness and timeliness of service provided.

To comply with regulatory and accreditation requirements, the QI Department may conduct annual medical record audits in Provider offices. A patient’s record will be reviewed for content and evidence that care and screenings have been documented, as applicable. Providers will be given results and a corrective action plan will be required if the score is lower than 80 percent.
The goal of conducting medical record reviews is multifold, including the ability of Missouri Care to assess the level of Provider compliance to documentation standards and clinical guidelines (disease and preventive, etc.), and to gauge quality of care and patient safety practices.

Missouri Care requires the following patient information documented in the medical record for each visit:

- A Member’s medical record should be neat, complete, clear, concise and timely and should include all recommendations and essential findings.
- All entries in the medical record must be signed, with professional delineation.
- All entries in the medical record must be dated and recorded in a timely manner.
- Medical records must be legible to readers and reviewing parties, and maintained in an orderly and detailed manner.
- The following personal and biographical data must be included in the record: name or identifier on one side of each page, date of birth or age, gender, personal contact information.
- All records must reflect the primary language spoken by the Member and translation/communication needs of the Member.
- Medication allergies or “no known allergies” and adverse reactions to drugs are prominently noted in the record.
- Age appropriate lifestyle and risk counseling is documented.
- A current medication list is available within the record.
- A problem list, with current diagnoses and procedures, including summary of significant surgical procedures is in the record.
- Screening for tobacco, alcohol or substance abuse is conducted, with appropriate counseling/referrals.
- There is documentation of screening for domestic violence with appropriate counseling/referrals, if needed.
- There is evidence the Member was provided with information on advance directives.
- Informed consent discussions, where appropriate, are detailed.
- History and physical examination as related to the visit, chief complaint or purpose of the visit and objective findings of the practitioner, diagnosis or medical impression.
- Plan of treatment, referrals, disposition, diagnostic testing, studies ordered, therapies administered and prescribed regimens.
- Follow-up plans for abnormal testing/consultation reports and referrals. There is documentation that the abnormal results or consultation reports were reviewed by the practitioner and the follow-up care to be done is also documented.
- Patient education and instruction, whether verbal, written or by telephone.
- Dispositions, recommendations and instructions to the Member.
- Documentation that the Member has received the Provider’s policy regarding office practices compliant with the Health Insurance Portability and Accountability Act (HIPAA).

The record shall contain evidence of the Provider’s knowledge of the Member’s course of care and adherence to continuity of care requirements and:

- Documentation and reports of consultations and referrals to specialty practitioners, if indicated.
• Reports of diagnostic testing – The medical record must show documentation of results for reports for diagnostic testing that were ordered.
• There is documentation in the record if a Member was seen in the emergency room.
• There is documentation in the medical record of the plan for hospital discharge.

The following standards are required according to MO HealthNet:

• Providers shall provide the full HCY/EPSDT services to all eligible children and young adults under the age of 21, and conduct and document well-child visits (screenings) using the state agency’s HCY/EPSDT screening form as amended. (The HCY screening form may be found on the internet at: manuals.momed.com/ under MO HealthNet Manuals, Forms, Healthy Children and Youth Screening [HCY Screening].) Direct Link: manuals.momed.com/manuals/presentation/forms.jsp.

• A full HCY/EPSDT well-child visit includes all of the components listed below. Segments of the full medical screen (partial screens) may be provided by different Providers. An interperiodic screen is defined as any encounter with a healthcare professional acting within his or her scope of practice.
  • A comprehensive health and developmental history including assessment of both physical and behavioral health developments
  • A comprehensive unclothed physical exam
  • Health education (including anticipatory guidance)
  • Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicted)
  • Appropriate immunizations according to age
  • Annual verbal lead risk assessment beginning at age 6 months and continuing through age 72 months using the HCY Lead Risk Assessment Guide Questionnaire that may be obtained at health.mo.gov/living/environment/lead/pdf/HCYLeadRiskAssessmentGuide.pdf
  • Blood lead level testing is mandatory at 12 and 24 months of age for all MO HealthNet children or annually for all children 6 months to 72 months of age if residing in an area designated as high risk for lead poisoning in Missouri as defined by Department of Health & Senior Services regulation 19 CSR 20-8.030
  • Hearing screening
  • Vision screening
  • Dental screening (oral exam by Primary Care Provider as part of comprehensive exam). Recommended that preventive dental services begin at age 6 through 12 months and be repeated every 6 months

• If a suspected problem is detected during a well-child visit, the child must be evaluated as necessary, using the required assessment protocol for further diagnosis. This diagnosis is used to determine treatment needs.

• HCY/EPSDT requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate (defined as “prevent from worsening”) defects, physical and behavioral health issues, and conditions discovered by the screening services or to correct a problem discovered during an HCY/EPSDT visit. All Medically Necessary
diagnosis and treatment services must be provided as long as they are permitted under
the Medicaid statute, whether or not they are covered under the state’s Medicaid plan, and
without any regard to any restrictions, the state may impose on services for adults.

- The state agency recognizes that the decision not to have a child screened is the right of
  the parent or guardian of the child.

For Members 21 years and older, the following adult preventive requirements from the
U.S. Preventive Task Force and the WellCare Clinical Practice Guidelines are required:

- Nutritional assessment
- Blood pressure, height and BMI checked every 1–2 years
- Vision screening annually if age 65+
- Pneumococcal vaccine, 1 dose if ages 65+
- Influenza vaccine annually
- Tetanus and diphtheria booster every 10 years
- Screening for cholesterol and dyslipidemia – at a minimum every five years – ages 35–
  65 for men and 45–65 for women
- Mammogram screening – Every one to two years after age 50
- Colorectal cancer screening – age 50 and older
- Pap smear and chlamydia screening for women – every one to three years

For pregnant Members, the following OB preventive screenings are required:

- Physical assessment that includes weight, blood pressure, fundal height and fetal
  heart tones
- Nutritional assessment and counseling
- Blood typing and antibody screening
- Rubella antititer
- Urinalysis
- Pap smear
- STD testing
- Hemoglobin and hematocrit tests
- HIV counseling and HIV testing
- HBsAG testing at the initial prenatal visit
- Depression screening
- Preterm delivery risk assessment
- Alpha-fetoprotein screening
- Diabetes screening
- Group B strep screening
- Postpartum exam

Documentation indicating diagnostic or therapeutic intervention as part of a clinical research
study is clearly contrasted from those entries pertaining to usual care.

Additional state requirements shall be included in the medical records as applicable.
In accordance with Senate Bill No. 1024, enacted by the General Assembly of the State of Missouri, Section A., Chapter 334, RSMo, amended to be known as Section 334.097, physicians shall maintain an adequate and complete medical record for each Member and may maintain electronic records provided the record-keeping format is capable of being printed for review. An adequate and complete medical record shall include documentation of the following information:

- Identification of the Member, including name, birth date, address and telephone number
- The date(s) the Member was seen
- The current status of the Member, including the reason for the visit
- Observation of pertinent physical findings
- Assessment and clinical impression of diagnosis
- Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the medical record the medication and dosage of any medication prescribed, dispensed or administered
- Any informed consent for office procedures

A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.

Any correction, addition or change in any medical record made more than forty-eight (48) hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

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 Missouri Care, or its representatives, without a fee to the extent permitted by state and federal law. The Member’s medical record is the property of the Provider who generates the record. Upon the written request of a Member, guardian, or legally authorized representative of a Member, a copy of the medical records of the Member's health history and treatment rendered shall be furnished. Such medical records shall be furnished within a reasonable time of the receipt of the written request. Each Member is entitled to one free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

Providers shall cooperate with the health plan to provide the state agency with access to all Members’ medical records, whether electronic or paper, within 30 calendar days of receipt of written request at no charge. The Provider shall cooperate with the health plan to provide the state agency with access to a single or small volume of medical records within five calendar days of receipt of written request at no charge. The Provider and health plan shall provide the state agency with immediate access for on-site review of medical records. For on-site review of medical records, the state agency may provide the health plan with an advance notice of a partial list of medical records. The Provider shall cooperate with the health plan to fax or send by overnight mail to the state agency all medical records involving an emergency or urgent care
issue when requested by the state agency at no charge. Access to record requirements applies to the health plan and all Providers.

The state agency is not required to obtain written approval from a Member before requesting the Member's record from the Provider. If the state agency requests, the Provider shall cooperate with the health plan to gather all medical records from Providers.

Providers shall cooperate with the health plan to ensure prompt retrieval of medical records and transfer of Member records upon request to other in-network or out-of-network providers for the medical management of Members. When a Member changes PCPs, upon request, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of request or prior to the next scheduled appointment to the new Primary Care Provider, whichever is earlier.

Medical records remaining under the care, custody, and control of the physician, physician’s designee, or healthcare Provider shall be maintained for a minimum of 10 years from the date of when the last professional service was provided. Providers should have procedures in place to permit the timely access and submission of medical records to Missouri Care upon request. Information from the medical records review may be used in the recredentialing process as well as quality activities.

Providers are required to keep a complete medical record of services provided and follow applicable state and federal statutes and regulations for medical record keeping and confidentiality in accordance with 13 CSR 70-3.030.

For more information on medical records compliance, including confidentiality of Member information and release of records, refer to Section 8: Compliance.

**Website Resources**
Missouri Care periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on the Missouri Care website. Please check frequently for the latest news and updated documents at [wellcare.com/Missouri/Providers/Medicaid](http://wellcare.com/Missouri/Providers/Medicaid).

**Patient Safety Plan**

**Overview**
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, Missouri Care supports identification and implementation of a complete range of patient safety activities. Some of the activities to ensure patient safety for Members include, but are not limited to, the following:

- Credentialing/Recredentialing to ensure a safe network of Providers
- Medical Record Review to ensure Members are getting needed care
- Member Satisfaction Surveys to ensure Members are getting needed care
- Provider Accessibility/Availability Monitoring to ensure an adequate network for Members
- Improve continuity and coordination of care to avoid miscommunication that can lead to poor outcomes

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- Use information from Quality of Practitioner Office Site Grievances/Site Visits to improve patient safety
- Distribute practice guidelines, such as HEDIS® Toolkits, to promote safe practice
- Monitor Potential Quality of Care concerns to identify issues that contribute to poor safety
- Analyze and take action on complaint and grievances that relate to safety
- Implement complex care management and disease management programs that include follow-up systems to ensure that care is received in a timely manner
- Ensure Utilization Management staff are meeting clinical standards through Inter-Rater Reliability & ensure reviews occur timely
- Assess the cultural needs of Members and Provider network and adjust accordingly to encourage optimal communication between Providers and Members
- Oversight of delegated entities to ensure Members are receiving needed care

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

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

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices and the Member’s needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee, with input from participating Providers, and the QI Committee. Activities include distribution of information, encouragement to use screening tools, and ongoing monitoring and measuring of outcomes. While Missouri Care implements activities to identify patient safety interventions, the support and activities of families, friends, Providers, and the community have a significant impact on prevention.

**Quality of Care Issues**

Quality of Care issues may be identified by Members, family/caretaker of Member, Providers, regulatory agencies, data mining/reports including Hospital Acquired Condition(s) (HAC)/Never Should Have Happened Event(s), or any department within Missouri Care. Quality of care issues may include procedural issues, delay/omission of care, post-op complications, medication issues, death or serious disability, patient safety, or quality of service.

Reviews are based upon assessment of Provider response, medical record documentation against Provider and/or health plan policies and procedures, regulatory and/or accreditation standards, and/or industry accepted clinical practice guidelines. In the event the peer reviewer/panel feels additional information is needed to address the issue, the Provider may be asked, in writing, to provide a response. The response is reviewed and a final determination is rendered.
Final determination is categorized in the following manner:

- Substantiated – There is evidence of a deviation in the standard of care.
- Unsubstantiated – There is no evidence of a deviation from the standard of care.

Once the final determination is made, the outcome is classified as either “adverse event” or “no adverse event.” Results of peer review activity may be reported to state and regulatory agencies as appropriate.

**Adverse Event Reporting**

Any injury, regardless of degree, or any adverse or unexpected occurrence incurred by a Provider or Member should be reported to Missouri Care.

*Adverse Events* are statutorily defined as any untoward, undesirable, and usually unanticipated incident that occurs while a Member is receiving healthcare services. Incidents such as patient falls or improper administration of medications are also considered Adverse Events even if there is no permanent effect on the patient. Adverse Events involving Missouri Care Members shall be reported to Missouri Care’s QI Department at **1-573-876-1522** or securely emailed to **.QOCInvestigationMissouriCare-Medicaid@wellcare.com** immediately as these events must be reported within 48 hours.

The following categories are used at the intake level when an event initially comes into the process. These event types are not all inclusive as not all categories are listed here.

<table>
<thead>
<tr>
<th>QOC Category</th>
<th>Types</th>
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<tbody>
<tr>
<td><strong>Procedural Issue</strong></td>
<td>Surgery performed on wrong side of patient’s body</td>
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<td></td>
<td>Surgery performed on the wrong patient</td>
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<td>A foreign body left in a patient after surgery</td>
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<td></td>
<td>Anesthesia-related event that led to death or serious disability</td>
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<td></td>
<td>Inappropriate/incorrect performance of a procedure</td>
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<td>A medical procedure that actually has or has the potential to cause a patient’s death, paralysis, coma or other major permanent loss of function</td>
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<tr>
<td><strong>Medication Issue</strong></td>
<td>A medication error that actually has or has the potential to cause a patient’s death, paralysis, coma, or other major permanent loss of function. Includes, but not limited to: omission error, dosage error, dose preparation error, wrong time, and wrong rate of administration, wrong administrative technique, and wrong patient</td>
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<tr>
<td><strong>Delay / Omission of Care</strong></td>
<td>Performance of a test</td>
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<td>Medical or surgical consultations</td>
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<td>Treatment or procedure</td>
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<td>Misdiagnosis</td>
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<td>Inadequate assessment</td>
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<td>Failure to comply with reporting laws</td>
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<tr>
<td><strong>Death or Serious Disability</strong></td>
<td>Medical or surgical consultations</td>
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<td>Inadequate assessment</td>
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<tr>
<td>Suicide/homicide or attempted suicide/homicide that results in serious injury or disability while in a healthcare facility</td>
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<tr>
<th>Post-op Complications</th>
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<tr>
<td>Wound infection resulting in increased LOS</td>
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<tr>
<td>Wound dehiscence resulting in increased length of stay and/or return to surgery</td>
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<tr>
<td>Hemorrhage</td>
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<tr>
<td>Perforation, laceration or tear</td>
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<tr>
<td>Admission after outpatient surgery</td>
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<tr>
<th>Patient Safety</th>
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<tbody>
<tr>
<td>Patient abduction from the facility</td>
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<tr>
<td>Sexual assault/harassment</td>
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<tr>
<td>Nosocomial infection</td>
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<tr>
<td>Fall</td>
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<tr>
<td>Restraint-related</td>
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<tr>
<td>Transfusion-related</td>
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</tbody>
</table>

Neglect, physical, emotional or sexual abuse while being cared for in a health care facility

Suicide attempt resulting in the need for medical care either during treatment or within 30 days of discharge from any BH level of care, and directly relating to a BH condition
- Inpatient, residential elopement from a behavioral health facility
- Self-inflicted injury while in an inpatient, residential or outpatient treatment facility
- Violent assaulting behavior on others or self, requiring hospitalization or involving potential for serious threat to life, either during treatment or within 30 days of discharge from a BH level of care

Providers are reminded that serious negative events or incidents, which occur in a Provider’s office or facility must be reported to the appropriate regulatory agency directly by the Provider.

**Patient Safety**

Missouri Care is committed to offering services that ensure safe delivery of clinical care to its Members. Through execution of standardized internal processes and collaborative participation of Providers, Missouri Care’s patient safety goal includes fostering a supportive environment to provide improved patient healthcare and safety. The goals of incorporating Patient Safety into Missouri Care’s QI Program are to:

- Promote patient safety as an integral component of healthcare delivery
- Reduce Member instances of potential quality issues which put patient safety at risk

The objectives of focusing on Patient Safety are to:

- Inform Members and providers regarding progress toward patient safety initiatives
- Encourage the practitioner and provider community to adopt processes to improve safe clinical practices
- Encourage Members to be participants in the delivery of their own safe healthcare
- Communicate patient safety best practices
In support of safe clinical practices, Missouri Care’s policies and procedures provide for the monitoring of quality of care issues.

Through tracking and trending of relevant plan metrics, Missouri Care can identify opportunities for improvement and facilitate education of a specific practitioner and/or Provider group at large in order to reduce the potential for patient safety incidents.

The scope of the Patient Safety Plan encompasses review of care and also administrative issues, such as Provider and patient interactions. The source of data to monitor aspects of patient safety could encompass, but is not limited to:

- Practitioner-to-practitioner communication
- Office site visit review results
- Medical record review findings
- Clinical practice guideline compliance
- Potential QOC (PQOC) tracking/trending
- Concurrent review during the Utilization Management process
- Identification of potential trends in underutilization and overutilization
- Care and Disease Management Program participation
- Pharmaceutical management practices
- Member communication
- Provider/practitioner actions to improve patient safety

Missouri Care addresses key elements of patient safety, such as coordination of care, medical record review findings, and adverse event and quality of care issues tracking/trending. Missouri Care defines specific areas of patient safety to be monitored based on trending data, which may include but are not limited to, the following metrics as indicators of safe clinical care:

- Number of quality of care issues
- Number of adverse events reported per quarter

Missouri Care may use newsletters, Provider Relations representatives, Quality Practice Advisors, and tailored education to periodically communicate key activities of patient safety initiatives, such as survey results, distribution of clinical practice guidelines, care gap reports, and HEDIS® Toolkits. Missouri Care is dedicated to improving safety and reducing medical errors for its Members.
Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)

Utilization Management

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

The goal of the UM Program is to achieve the best outcomes while providing quality healthcare at the most appropriate setting and the most appropriate time for the Members. The UM Program:

- Ensures culturally sensitive delivery of services that are Medically Necessary, appropriate and are consistent with the Member’s diagnosis and level of care required
- Provides access to the most appropriate and cost efficient healthcare services. Ongoing monitoring, tracking and trending of care rendered to Missouri Care’s Members in order to ensure that quality healthcare is provided
- Works collaboratively with the CM, DM, and QI Departments by identifying and referring potential quality of care issues for review and implementation of intervention plans, as indicated
- Monitors overutilization and underutilization, continuity and coordination of care and implements corrective action intervention plans, as needed
- Works collaboratively with the Provider Services Department and the Appeals and Grievance Committees with timely review and response to Member or Provider grievances/appeals relating to UM decisions
- Facilitates communication and partnerships among participants, physician Providers, facility Providers, delegated entities and Missouri Care in an effort to enhance cooperation and appropriate utilization of healthcare services
- Monitors, implements and maintains systems to enable compliance with government and legislative requirements of UM processes

Providers can access WellCare UM staff to discuss issues. Per NCQA Standard UM3, WellCare provides the following communication services for Members and Providers:

- Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues;
- Staff can receive inbound communication regarding UM issues after normal business hours;
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues;
- Multilingual and TDD/TTY services, and American Sign Language services, for Members who need them; and
- Language assistance for Members to discuss UM issues.
Availability of Utilization Management Staff
WellCare’s Health Services Department provides medical and support staff resources, including a Medical Director, to process requests and provide information for the routine or urgent authorization/pre-certification of services, utilization management functions, Provider questions, comments or inquiries. We are available 24 hours a day, seven days a week, including holidays.

For more information on contacting the Health Services Department via Provider Services, refer to the state-specific Quick Reference Guide on WellCare’s website at www.wellcare.com/provider/quickreferenceguides.

After-Hours Utilization Management
WellCare processes requests and provides information for the routine or urgent authorization of services, Utilization Management functions, Provider and Member questions or comments 24 hours a day, seven days a week. Providers requesting after-hours authorization for inpatient admission should refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/Missouri/Providers/Medicaid/forms 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.

Medically Necessary Services
The determination of whether a Covered Benefit or service is Medically Necessary complies with the requirements established in Missouri Care’s contract with MO HealthNet. Please refer to Section 11: Definitions for the definition of Medical Necessity.

Missouri Care provides Covered Services to Members, sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting.

Missouri Care’s UM Program includes components of prior authorization, prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of healthcare and services based on Missouri Care Members’ coverage, and the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

Missouri Care does not reward practitioners, Providers or associates who perform utilization reviews, including employees of delegated entities, for denials. No one is compensated or otherwise given incentives to encourage denials that result in underutilization. Utilization reviews are based on appropriateness of care and existence of coverage. Utilization denials (adverse determinations) are based on lack of Medical Necessity or lack of Covered Benefits.

Criteria for UM Decisions
Missouri Care’s UM Program uses nationally recognized review criteria based on sound scientific, medical evidence. Physicians with an unrestricted license in the state of Missouri and professional knowledge and/or clinical expertise in the related healthcare specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.
The UM Program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- InterQual™, through March 3, 2019
- Milliman Clinical Guidelines (MCG), effective March 4, 2019
- LOCUS
- CALOCUS
- Missouri Care Clinical Coverage Guidelines
- Medical Necessity
- Member benefits
- State Medicaid Contract
- State Provider Manuals, as appropriate
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment

The reviewer and/or medical director involved in the UM process applies 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 contacting the UM Department via Provider Services. The phone number is listed on the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

**Utilization Management Process**

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

- Notifications
- Referrals
- Prior Authorizations/Pre-certification (Prospective Review)
- Concurrent Review
- Discharge Planning
- Retrospective Review

The UM Department adheres to state, federal, and accreditation standards for service authorization decisions and adverse determinations, which include notification time frames. These standards are applied to urgent/expedited and routine requests for prospective, concurrent and retrospective services.

Missouri Care’s forms for the submission of notifications and authorization requests are on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid/Forms.

**Notification**

Notifications are communications to Missouri Care with information related to a service rendered to a Member or a Member’s admission to a facility. Notification is required for:
• Prenatal services. This enables Missouri Care to identify pregnant Members for inclusion in the Prenatal Program and identify Members who may benefit from the High-Risk Pregnancy Program. Obstetrical Providers are required to notify Missouri Care of pregnant Members via fax using the Pregnancy Risk Screening Form within two business days of the initial visit. This process will expedite care management and claims reimbursement.
• A Member’s admission to a hospital, to include observation admissions. This enables Missouri Care 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
For an initial referral, Missouri Care does not require authorization as a condition of payment if the service is done in the Missouri Care network. Certain diagnostic tests and procedures considered by Missouri Care to be routinely part of an office visit may be conducted as part of the initial visit without an authorization if the services are done in network. Please refer to the authorization look up tool on Missouri Care’s website at wellcare.com/Missouri/Providers/Authorization-Lookup.

Referrals may be made to an out-of-network provider and may be authorized by Missouri Care if the Covered Services are not available in network. All out-of-network referrals require prior authorization by Missouri Care.

Prior Authorization
Prior authorization allows for efficient use of Covered Services by facilitating Members to receive the most appropriate level of care, in the most appropriate setting. Prior authorization may be obtained by the Member’s PCP or by a treating specialist or facility.

Reasons for requiring prior authorization may include:
• Review for Medical Necessity
• Appropriateness of rendering Provider
• Appropriateness of setting
• Case and disease management considerations

Prior authorization is required for elective or non-emergency services as designated by Missouri Care. Prior authorization requirements by service type may be found on the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid. Providers can also use the searchable Authorization Lookup Tool at wellcare.com/Missouri/Providers/Authorization-Lookup. Providers will need to register and log in to use this secure tool.

Requests for prior authorization can be submitted to Missouri Care by:
• Submitting an online authorization request via the secure provider web portal at www.wellcare.com/missouri (this option provides faster service)
• Faxing a properly completed Inpatient, Outpatient, Durable Medical Equipment (DME) and Orthotic and Prosthetic, or Home Health and Skilled Therapy Services Authorization Request Form to 1-866-946-2052; or
• Contacting Provider Services directly at 1-800-322-6027 for inpatient notifications and urgent outpatient services.

Some prior authorization guidelines to note are:
• The prior authorization request should include the diagnosis to be treated and the Current Procedural Terminology (CPT) code describing the anticipated procedure. The authorization request should outline the plan of care, including the frequency and 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.

Authorization Request Forms
Missouri Care requests Providers use our standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to your request, including:
• Inpatient Log Sheet is used to submit notification of an inpatient and observation admission: elective, acute, skilled nursing facility, rehabilitation, long-term and subacute admissions.
• Prior Authorization Request Form is used to submit authorization requests for select outpatient surgical, diagnostic, and therapeutic services including transition-of-care and out-of-network requests.
• Behavioral Health Form is used to submit authorization requests for non-par outpatient requests.
• Therapy Services Request Form is used to submit authorization requests for Occupational, Physical and Speech Therapy services.
• Home Health Services Request Form is used to submit authorization requests for home health services including skilled nursing.
• Durable Medical Equipment Request Form is used to request all equipment including orthotics and prosthetics.
• Enteral Formula Request Form is used to request enteral nutrition, formula and supplies.
• A Pregnancy Risk Screening Form should be completed by the obstetrician/gynecologist (OB/GYN) during the first visit and faxed to Missouri Care within 2 business days of the initial visit. Notification of obstetric services enables Missouri Care to identify Members for inclusion into the Prenatal Program and/or Members who might benefit from Missouri Care’s High Risk Pregnancy Program.

To ensure timely and appropriate claims payment, all forms must:
• Have all required fields completed; to include Member name, date of birth, MO HealthNet or Missouri Care identification number, diagnosis and Current Procedural Terminology (CPT) codes/description
• Be typed or printed in black ink for ease of review
• Contain a clinical summary or have supporting clinical information attached

Prior authorization requirements by service type are in the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid. Providers can also use the searchable Authorization Lookup Tool located on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Authorization-Lookup.
Providers will need to register and log in to use this secure tool.

Forms are located on Missouri Care’s website at [www.wellcare.com/Missouri/Providers/Medicaid/Forms](http://www.wellcare.com/Missouri/Providers/Medicaid/Forms). All forms should be submitted via fax to the number listed on the form.

**Exceptions**
Requests for exceptions to non-Covered Benefits must demonstrate at least one of the following:
- Item or service required to sustain life
- Item or service would substantially improve the quality of life for a terminally ill patient
- Item or service is necessary as a replacement due to a violence of nature
- Item or service is necessary to prevent a higher level of care

Any procedure must be listed in the current CPT code book. The Member must be eligible on the dates of service and the physician or Provider of service must be enrolled in the Medicaid program on the date the item or service is provided. The item or service must not depart from accepted medical standards. Reimbursement will be made in accordance with the Medicaid established fee schedule.

The services requested must meet Medical Necessity criteria and must be prior authorized by the medical director. These exceptions will be time-limited, and will be made on a case-by-case basis. In no event will the decision on an individual case be construed to set precedent for future cases.

Member’s PCP must inform the company of their desire for an exception. Any requests that do not meet the policy guidelines listed above will be denied.

The request must be accompanied by medical records documenting the current status and treatment outcomes, the two proposed treatment plans if appropriate (one through Covered Benefits available and one through non-Covered Benefits available), and the time frames and outcomes expected for the different options.

Both options will be evaluated for cost-benefit and a final exception decision will be made by the medical director based on the specifics of the individual case.

The *Exceptions Request Form* can be found on Missouri Care’s website at [www.wellcare.com/Missouri/Providers/Medicaid/Forms](http://www.wellcare.com/Missouri/Providers/Medicaid/Forms).

**Concurrent Review**
Concurrent review activities involve the evaluation of a twenty-four (24) hour observation stay, a continued hospital, Long-Term Acute Care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the Member through telephonic, fax or chart review and communication with the attending physician, hospital utilization manager, CM staff or hospital clinical staff involved in the Member’s care. Concurrent review is initiated after Missouri Care 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™, through March 3, 2019, Milliman Clinical Guidelines (MCG), effective March 4, 2019, or LOCUS/CALOCUS criteria for appropriateness of continued stay to:

- Promote the delivery of services in a timely and efficient manner;
- Promote meeting established standards of quality care;
- 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™, through March 3, 2019, Milliman Clinical Guidelines (MCG), effective March 4, 2019, or LOCUS/CALOCUS criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed clinicians under the direction of the Missouri Care Medical Director.

To ensure the review is completed in a timely manner, Providers must submit notification and clinical information the next business day after the admission, as well as upon request of the Missouri Care review clinician. Failure to submit necessary documentation for concurrent review may result in a denial for continued services and non-payment.

- Hospitals must notify Missouri Care by phone or via the inpatient notification form by fax by the next business day following the admission. Behavioral health inpatient requests must be submitted by fax. No authorization will be made at this time, unless all clinical information is provided. Clinical information must be provided on the next business day if not already presented at the time of notification.
- Missouri Care has staff available 24 hours a day, seven days a week. If a hospital would like to have an immediate authorization decision rendered, and is able to provide clinical information at the time of notification, the call will be transferred to the nurse review staff (or on-call nurse) to provide a response within one hour.
- A Missouri Care nurse will review the clinical information, and will respond to the facility with an authorization status decision within one day after receipt of the information.
- If a Member is admitted, and subsequently discharged before the next business day (i.e., over a weekend), the facility must still notify Missouri Care and provide clinical information so that an authorization decision can be made.
- Facilities must notify Missouri Care of admissions for the delivery of newborn or stillborn babies. Notification should be by fax, using the Birth Notification Form, by the next business day following the birth. Baby clinical information (gender, weight, date of birth) must be provided no later than the next business day, if not included in the initial notification. Missouri Care will respond to the facility with an authorization number within one business day, to include 36 hours of the receipt of complete information.
- Failure of a hospital(s) to notify Missouri Care of a Member’s inpatient admission by the next business day, or failure to communicate information related to service(s) rendered to a Member will result in the denial of the submitted claim(s) associated with the said admission or service(s).
Based on professionally generated criteria, Missouri Care will review all admissions to and services provided in an acute care setting. All participating hospital reviews must comply with procedures outlined in the hospital's utilization review plan. An entry must be made in the utilization review notes on the review date, indicate the name and title of the reviewer and be signed by the reviewer. This entry must also indicate the severity of illness/intensity of service (SI/IS) criteria that was met for Medical Necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of reimbursement of your claim.

If the hospital uses an electronic entry system for utilization review, the entry must indicate a unique identifier with the name and title of the reviewer on file as well as the date the entry was made.

**Discharge Planning**

Discharge planning begins upon admission and is an essential part of the concurrent review process. It is designed to quickly identify medical and/or psychosocial issues that will need post-hospital intervention. It may include coordinating services required to assist in arranging for and implementing a Member's transition to a more appropriate or lower level of care, as needed. The concurrent review clinician coordinates services with the PCP, attending physician, and/or the discharge planning personnel at the hospital.

The concurrent review clinician 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 review clinician may refer an inpatient Member with identified complex discharge needs to CM for post-discharge follow-up.

When a covered Member is hospitalized, and is disenrolled from Missouri Care during the hospital stay, Missouri Care shall maintain responsibility for the coordination of care and discharge planning for that Member.

When a covered newborn remains hospitalized and is disenrolled from Missouri Care during the hospitalization, Missouri Care shall remain responsible for the coordination of care and discharge planning until the child has been appropriately discharged from the hospital and placed in an appropriate care setting.

**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 Missouri Care may perform:

- Retrospective Review initiated by Missouri Care: It is the policy of Missouri Care to assure, through Retrospective Review, the compliance by Providers to generally acceptable coding guidelines. Retrospective Review will request specific medical records from the Provider in order to conduct this review to determine if coding compliance is accurate and appropriate.
- Retrospective Review initiated by Providers: Under applicable situations (e.g., if a Member is admitted and discharged from a hospital before concurrent review is conducted), Providers may request retrospective review of services that have already
been performed. Retrospective review determinations are reviewed applying the same approved medical criteria as for concurrent determinations. Post-service authorization requests are also reviewed to determine if any of the following circumstances exist:

- The Provider was not able to determine the Member’s eligibility.
- The service was urgent in nature and there was not time to submit a request prior to service delivery.
- The service is part of an ongoing plan of treatment for a newly eligible Member.
- Extenuating circumstances existed that precluded the Provider from submitting a timely pre-service or concurrent review authorization request, i.e., a procedure was performed that did not require prior authorization but while doing the procedure another procedure was warranted that required prior authorization. In this instance, please notify Missouri Care’s prior authorization department the next business day to request authorization.

Providers are expected to adhere to the business rules for submission of service authorization requests. Post-service requests that do not meet one of the above conditions may be administratively denied. Exceptions may be granted if specifically addressed through contract language. Retrospective review requests must be submitted in writing within 90 days of the Member’s discharge date. Missouri Care will communicate decisions to the requesting practitioners/Provider and the Member, if applicable, within 30 calendar days of receipt of the request.

The Member or Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the UM Department via Provider Services. Refer to the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

Service Authorization Decisions

<table>
<thead>
<tr>
<th>Type of Authorization</th>
<th>Decision</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Pre-service</td>
<td>36 hours to include one working day</td>
<td>Not to exceed 14 calendar days from receipt of request</td>
</tr>
<tr>
<td>Expedited (Urgent) Pre-service</td>
<td>24 hours</td>
<td>N/A</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>24 hours</td>
<td>N/A</td>
</tr>
<tr>
<td>Post-service</td>
<td>30 calendar days</td>
<td>Not to exceed 14 calendar days</td>
</tr>
</tbody>
</table>

**Standard Service Authorization**

Missouri Care will provide a service authorization decision as expeditiously as the Member’s health condition requires and within state-established time frames, which will not exceed 36 hours to include one working day following receipt of the request for service. In no case shall the health plan exceed 14 calendar days following the receipt of the request of service to provide approval or denial.

The decision time frame may be extended beyond 14 days if:
- The Member, or the Provider, requests an extension, or
- Missouri Care justifies (to the state agency upon request) a need for additional information and how the extension is in the Member’s best interest.

Missouri Care will fax an authorization response to the Provider fax number(s) included on the authorization request form.

**Expedited Service Authorization**

If a Provider indicates, or Missouri Care determines, that following the standard time frame could seriously jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function, Missouri Care must make an expedited authorization decision and provide notice within 24 hours after receipt of the request for service.

Requests for expedited decisions for prior authorization can be submitted through Missouri Care’s secure, online provider portal, by fax or by phone.

Please refer to the *Quick Reference Guide* to contact the UM Department via Provider Services, which may be found on Missouri Care’s website at [www.wellicare.com/Missouri/Providers/Medicaid](http://www.wellicare.com/Missouri/Providers/Medicaid).

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

**Urgent Concurrent Authorization**

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

- The request to extend urgent concurrent care is not received at least 24 hours prior to the expiration of the previous authorization, or
- Previous care was not authorized, and Missouri Care was not able to obtain needed clinical information within the initial 24 hours after the request, with at least one documented request for the clinical information.

**Services Requiring No Authorization**

In order to facilitate timely and effective treatment of Members, Missouri Care has determined that many routine procedures and diagnostic tests are allowable without medical review, including:

- Certain diagnostic tests and procedures considered by Missouri Care to routinely be part of an office visit. Routine clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require prior authorization. The exceptions to this rule are:
  - Reproductive laboratory tests
  - Molecular laboratory tests
  - Cytogenetic laboratory tests
- Certain tests described as CLIA-waived may be conducted in the physician’s office if the Provider is authorized through the appropriate CLIA certificate. A copy of the certificate must be submitted to Missouri Care.
Prior authorization requirements by service type may be found on the *Quick Reference Guide* on Missouri Care’s website or on the searchable Authorization Lookup Tool, at [www.wellcare.com/Missouri/Providers/Medicaid](http://www.wellcare.com/Missouri/Providers/Medicaid) or [www.wellcare.com/Missouri/Providers/Authorization-Lookup](http://www.wellcare.com/Missouri/Providers/Authorization-Lookup). Providers will need to register and log in to use this secure tool.

**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 (NOA) communication. The treating physician is provided the toll-free number of the health plan to request a discussion with the Missouri Care Medical Director who made the denial determination. Peer-to-Peer Reconsideration is offered when requested within three business days of the denial determination. The health plan medical director will make two attempts to contact the treating practitioner and conduct the review. The physician will have the opportunity to discuss the decision with the peer clinical reviewer making the determination or with a different clinical peer if the original reviewer is not available. The peer-to-peer dialogue must be completed within five business days of the denial determination. The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process. In the event the peer-to-peer dialogue does not occur during the specified time frames, the Provider will have the opportunity to use the standard Provider appeals process.

**Missouri Care Proposed Actions**

A proposed action is an action taken by Missouri Care to deny a request for services. In the event of a proposed action, Missouri Care will notify the Member and the requesting Provider in writing of the proposed action. The notice will contain the following:

- The action Missouri Care has taken or intends to take
- The reason(s) for the action
- The Member’s or Provider’s right to appeal
- The Member’s right to request a state fair hearing
- Procedures for exercising the Member’s rights to appeal or file a grievance
- The Member’s right to represent himself/herself or use legal counsel, a relative, or a friend
- The specific regulations that support or the change in federal or state law that requires the action
- The Member’s right to request a state agency hearing, or in cases of an action based on change in law, the circumstance under which a hearing will be granted
- Circumstances under which expedited resolution is available and how to request it
- The Member’s rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued

**Second Medical Opinion**

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the healthcare team, including a Member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility. The second opinion must be provided by a qualified healthcare professional within the network, or Missouri Care shall arrange for the Member to obtain one outside the network if there is not a
participating Provider with the expertise required for the condition. The second opinion shall be provided at no cost to the Member. Certain elective surgical procedures, pursuant to Missouri Law require a second medical opinion be provided prior to surgery.

A third surgical opinion, provided by a third Provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the Member desires the third opinion.

Missouri Care’s Prior Authorization Department can assist in coordinating the second or third opinion with an in-network or out-of-network provider by calling Provider Services at 1-800-322-6027.

**Emergency/Urgent Care and Post-Stabilization Services**

Emergency services are not subject to prior authorization requirements and are available to Members 24 hours a day, seven days a week. See *Section 13: Definitions* for definitions of “emergency” and “urgent.” Urgent care services are provided as necessary and are not subject to prior authorization or pre-certification.

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 Missouri Care is notified that the Member’s condition has stabilized.

**Continuation of Care**

In the event that a physician should terminate his or her contract with Missouri Care, Members in active treatment may continue to receive care from the terminated Provider in the following circumstances:

- Pregnancy;
- A disability, life-threatening illness;
- Active stage of an illness; or
- Serious medical condition.

If a Member is receiving treatment from the terminated Provider and the 90-day transition period has expired, Missouri Care will consider whether an in-network Provider could provide the Medically Necessary services or if continued care with the terminated Provider must be continued.

For continued care under this provision, the terminated Provider accepts the following:

- Reimbursement rate of 100 percent of the Medicaid fee schedule
- Payment from Missouri Care as payment in full (no balance billing) and shall not collect payment from Members except for:
  - Applicable MO HealthNet cost-sharing amounts.

When services are not in the comprehensive benefit package, the practitioner or Provider shall inform the Member that the services are not covered prior to providing the services, and shall obtain acknowledgement from the Member. If the Member still wants to proceed with the service, the practitioner or Provider shall obtain such acknowledgement in writing (a private pay agreement) prior to rendering the service. Regardless of any understanding worked out
between the practitioner or Provider and the Member about private payment, once the practitioner or Provider bills Missouri Care for the service, the prior arrangement with the Member becomes null and void.

**Transition of Care**
The health plan shall provide continuation of Medically Necessary Covered Services for the lesser of 60 calendar days or until the Member has transferred, without disruption of care, to an in-network Provider. Missouri Care 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 Missouri Care’s network until such time as Missouri Care 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 Missouri Care is necessary to properly document these services and determine any necessary follow-up care.

After the initial 60 days, Providers are required to follow Missouri Care’s prior authorization or concurrent review requirements.

When relinquishing Members, Missouri Care will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider.

When Missouri Care becomes aware that a covered Member will be disenrolled from Missouri Care and will transition to another health plan or to a fee-for-service (FFS) Missouri Medicaid program a Care Manager who is familiar with that Member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contract person for the designated FFS program.

Missouri Care must identify and facilitate coordination of care for Members during changes or transitions between plans. Members with special circumstances may require additional and/or distinctive assistance during the transition period. Special circumstances include Members designated as having "special healthcare needs."

If a Provider receives an adverse claim determination which they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals Department with documentation for reconsideration. Refer to the *Quick Reference Guide* on Missouri Care’s website at [www.wellcare.com/Missouri/Providers/Medicaid](http://www.wellcare.com/Missouri/Providers/Medicaid) for the Appeals Department contact information.

**Limits to Abortion, Sterilization, and Hysterectomy Coverage**
The following services have special requirements from the State of Missouri.

**Abortion**
Prior authorization is not required for abortion procedures. However, Missouri Care will deny any Provider claims submitted without the required abortion certification form or with an incomplete or inaccurate abortion certification form.
Abortions are covered for eligible Missouri Care Members if the Provider certifies that the abortion is Medically Necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

Abortions are not covered if used for family planning purposes. A Certification Of Medical Necessity For Abortion Form [MO886-3255 (10-07)] must be properly executed and submitted to Missouri Care with the Provider’s claim. This form may be filled out and signed by the physician and is located at manuals.momed.com/. 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, Missouri Care also requires the submission of the History, Physical and Operative Report and the Pathology Report with all claims that have ICD-10-CM procedure codes to ensure that abortions are not being billed through the use of other procedure codes.

**Sterilizations**

Missouri Care will not and is prohibited from making payment for sterilizations performed on any person who:

- Is under 21 years of age at the time he or she signs the consent; or
- Is not mentally competent.

The Sterilization Consent Form (PSFL-200) form is required for sterilizations. This form can be found at manuals.momed.com/forms/(Sterilization)Consent_Form(MO-8812).pdf. Prior authorization is not required for sterilization procedures. However, Missouri Care 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. The day after the signing is considered the first day when counting the 30 days.

In the case of premature delivery, the consent form must be completed and signed by the Member at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery. For emergency abdominal surgery, the consent form must be completed and signed by the Member at least 72 hours prior to the sterilization procedure. Although these exceptions are provided, the conditions of the waiver will be subject to review.

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 Missouri Care. The Member must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.
**Hysterectomy**

Prior authorization is required for the administration of a hysterectomy to validate Medical Necessity when performed in an inpatient setting. Missouri Care reimburses Providers for hysterectomy procedures only when the following requirements are met:

- The Provider ensured that the individual and her representative (e.g., legal guardian, husband, etc.) 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 *Acknowledgement of Receipt of Hysterectomy Information Form* [MO886-3280 (9-95)]. The form can be found at [manuals.momed.com/forms/Acknowledgement_of_Receipt_of_Hysterectomy.pdf](manuals.momed.com/forms/Acknowledgement_of_Receipt_of_Hysterectomy.pdf)

- Exceptions to the requirement for an *Acknowledgement of Receipt of Hysterectomy Information Form* may be made in the following situations:
  - The Member was already sterile before the hysterectomy. The physician who performs the hysterectomy must certify in writing that the Member was already sterile at the time of the hysterectomy and state the cause of the sterility. This must be documented by an operative report or admit and discharge summary;
  - The Member requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgement is not possible. The physician must certify in writing to this effect and include a description of the nature of the emergency; or
  - The Member was not MO HealthNet eligible at the time the hysterectomy was performed but eligibility was made retroactive to this time. The physician who performed the hysterectomy must certify in writing to one of the following situations:
    - The Member was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;
    - The Member was already sterile before the hysterectomy; or
    - The Member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible.

A hysterectomy is not covered when:

- The hysterectomy was performed solely for the purpose of rendering a Member permanently incapable of reproducing; or
- There was more than one purpose to the procedure. The hysterectomy would not have been performed but for the purpose of rendering the Member permanently incapable of reproducing.

Missouri Care will deny payment on any claims submitted without the required documentation or with incomplete or inaccurate documentation. Missouri Care does not accept documentation meant to satisfy informed consent requirements, which has 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.

**Delegated Entities**

Missouri Care delegates some UM activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for UM activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required UM standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of Missouri Care and the delegated entities. Contract must be approved by MO HealthNet prior to implementation.

Delegation of select functions may occur only after an initial audit of the UM activities has been completed and there is evidence that Missouri Care’s delegation requirements are met. These requirements include:

- A written description of the specific UM delegated activities;
- Semi-annual reporting requirements;
- Evaluation mechanisms; and
- Remedies available to Missouri Care if the delegated entity does not fulfill its obligations.

Children’s Mercy Pediatric Care Network (CMPCN) is an integrated pediatric network operated by the Children’s Mercy Hospital System. CMPCN will provide delegated medical management services including: care management, utilization management and disease management for select Missouri Care Members in the following counties: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair and Vernon.

All medical management services will be provided by CMPCN for Missouri Care Members up to age 20, who are assigned to a Primary Care Provider in any of the above counties. All behavioral health management services will continue to be managed by Missouri Care.

CMPCN is comprised of Children’s Mercy Hospital and its employed physicians and other contracting Primary Care Providers located in the counties above. Please note however, that although medical management services will be provided by CMPCN, a Missouri Care Member is still free to choose any contracted Provider to receive services. However, if an authorization is necessary, or you have a referral for care management, you will contact CMPCN instead of Missouri Care. Please call 1-877-347-9367 for CMPCN Member prior authorization requests.

**EviCore Health CareNational**

EviCore National is our vendor for the following programs:

- Advanced Radiology
- Cardiology
- Molecular and genetic laboratory testing
- Pain management
- Physical and Occupational Therapy
- Radiation Therapy Management
- Sleep Diagnostics
Contact EviCore for all authorization-related submissions for the services listed above rendered in outpatient places of service. EviCore’s authorization requirements may differ from the guidelines Missouri Care previously used – including EviCore’s requirement to obtain authorization for all OB ultrasounds. For EviCore’s authorization requirements please visit www.carecorenational.com or call EviCore directly at 1-888-333-8641. Authorization requests may be submitted through the web portal at www.carecorenational.com or via fax at 1-866-896-2152. For urgent authorizations or for Provider Services inquiries call 1-888-333-8641.

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

**Care Management Program**

**Overview**
Missouri Care offers comprehensive integrated Care Management (CM) services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. Missouri Care trusts Providers will help coordinate the placement and cost-effective treatment of patients who are eligible for Missouri Care CM Programs.

Missouri Care’s multidisciplinary CM teams are led by specially trained Registered Nurses (RN) or Licensed Behavioral Health Care Managers who perform a comprehensive assessment of the Member’s clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome 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.

Missouri Care’s CM teams also serve in a supportive capacity to the PCP and assist in actively linking the Member to Providers, medical and behavioral services, residential, social and other support services, as needed. A Provider may request Care Management services for any Missouri Care Member.

The CM process begins with Member identification and follows the Member until discharge from the program. Members may be identified for CM by:
- Referral from a Member’s PCP or specialist;
- Self-referral;
- Referral from a family Member;
- Referral after a hospital discharge;
- Completion of a Health Risk Assessment (HRA);
- DM Program referral; and/or
- Data mining for Members with high utilization.

Missouri Care’s philosophy is that the CM Program is an integral management tool in providing a continuum of care for Missouri Care Members. Key elements of the CM 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 them with appropriate clinical needs;

- **Care Planning** – Collaboration with the Member and/or caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the 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; and

- **Member Advocacy** – Advocating on behalf of the Member within the complex labyrinth of the healthcare system. Care Managers assist Members with seeking the services to optimize their health. CM emphasizes continuity of care for Members through the coordination of care among physicians, Community Mental Health Centers, and other Providers.

Members with the following concerns are commonly included in the CM Program:

- **Catastrophic** – Traumatic injuries, e.g., 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), hypertension, cancer, cardiac disease or multiple intricate barriers to quality health care, e.g., Acquired Immune Deficiency Syndrome (AIDS), and chronic pain;

- **Transplantation** – Organ failure, donor matching, post-transplant follow-up;

- **Complex Discharge Needs** – Members discharged home from an acute inpatient stay or Skilled Nursing Facility (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 physical, mental or developmental disabilities; sickle cell, hepatitis, pervasive development disorder, anxiety disorders;

- **Pregnant Members**;

- **Members with Elevated Lead Levels** – Any Member with a lead level greater than 10 ug/dl must be referred for care management; and

- **Members with Co-occurring Behavioral Health and Substance Abuse**.

**Disease Management Program**

**Overview**

Disease Management (DM) 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 CPGs) 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);
• Chronic obstructive pulmonary disease (COPD);
• Diabetes – adult and pediatric;
• Hypertension; and
• Depression.

Missouri Care’s DM 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 Providers regarding 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, Missouri Care makes general information available to Providers and Members regarding health conditions on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Clinical-Guidelines/CPGs.

Candidates for Disease Management
Missouri Care encourages referrals from Providers, Members, hospital discharge planners and others in the healthcare community.

Interventions for Members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized CPGs. Members identified at the highest stratification levels receive a comprehensive assessment by a DM 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 CPGs adopted by Missouri Care may be found on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Clinical-Guidelines/CPGs.

Access to Care and Disease Management Programs
If you would like to refer a Missouri Care Member as a potential candidate to the CM or DM Programs, or would like more information about one of the programs, you may call the Missouri Care Management Referral Line. 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 Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.
Section 5: Claims

Overview
The focus of Missouri Care’s Claims Department is to process claims in a timely manner. Missouri Care has established toll-free telephone numbers for Providers to access a representative in our Provider Services Department.

For more information, refer to the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process
WellCare (in partnership with PaySpan®) has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

Once a Provider is registered, this no-cost secure service offers Providers a number of options for viewing and receiving remittance details, ERAs can be imported directly into practice management or patient accounting system, eliminating the need to rekey remittance data. Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers do not receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from PaySpan’s website, once registration is completed. Providers can register using PaySpan’s enhanced Provider registration process at: payspan.com. Providers can also view PaySpan’s webinar anytime at: payspan.webex.com.

PaySpan Health Support can be reached via email at Providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the web at payspanhealth.com.

Timely Claims Submission
When Missouri Care is the primary payer, first submission timely filing is 180 days, unless otherwise defined by your contract. For coordination of benefits, Providers have 365 days from date of service or 90 days from the date of the primary Explanation of Benefits (EOB); whichever time frame is longer to submit. Providers have 365 days from the date of service to correct and resubmit corrected claims. The start date for determining the timely filing period is the “from” date reported on a CMS-1500 or 837-P for professional claims or the “through” date used on the UB-04 or 837-I for institutional claims. Unless prohibited by federal law or the Centers for Medicare & Medicare Services (CMS), Missouri Care may deny payment for any claims that fail to meet Missouri Care’s submission requirements for Clean Claims or that are received after the time limit in the Contract for filing Clean Claims. A Provider whose claim is denied as described in this paragraph must not bill or accept payment from the Member for the services in question.

The following items can be accepted as proof if a Clean Claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Missouri Care; and
• A Provider’s electronic submission sheet with all the following identifiers:
  o Patient name;
  o Provider name;
  o Date of service to match Explanation of Benefits (EOB)/claim(s) in question;
  o Prior submission bill dates; and
  o Missouri Care 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 (TIN) and National Provider Identifier (NPI) Requirements**
Missouri Care requires the payer-issued Tax Identification (Tax ID/TIN) and National Provider Identifier (NPI) on all claims submissions. Missouri Care will reject claims without the Tax ID and/or NPI. More information on NPI requirements, including HIPAA’s NPI Final Rule Administrative Simplification, is available on the Centers for Medicare and Medicaid Services (CMS) website at [www.cms.gov](http://www.cms.gov).

**Preauthorization Number**
If a preauthorization number was obtained, it is recommended that Providers include this number in the appropriate data field on the claim to reduce processing errors.

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

**Strategic National Implementation Process (SNIP)**
All claims and encounter transactions submitted via paper, Direct Data Entry (DDE) or electronically will be validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines.

If a claim is rejected for lack of compliance with Missouri Care’s claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits based on the date of service (those limits are described above until “Timely Claims Submission”). For more information, see the Encounters Data section below.

**Claims Submission Requirements**
When presenting a claim for payment to Missouri Care, the Provider is indicating an understanding that:
• The Provider has an affirmative duty to supervise the provision of, and be responsible for, the Covered Services claimed to have been provided;
• To supervise and be responsible for preparation and submission of the claim; and
• To present a claim that is true and accurate and is for health plan Covered Services that:
  o Have actually been furnished to the Member by the Provider prior to submitting the claims; and
  o Are medically necessary.
Providers using electronic submission shall submit all claims to Missouri Care or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or an original (red and white) 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 Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

Electronic Claims Submissions
Missouri Care accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Missouri Care must be in the ANSI ASC X12N format, version 5010. For more information on EDI implementation with Missouri Care, refer to the Missouri Care Companion Guides which may be found on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or with Missouri Care’s contracted clearinghouse, to establish EDI with Missouri Care. For information on the unique Missouri Care Payer Identification (Payer ID) numbers used to identify Missouri Care on electronic claims submissions, or to contact Missouri Care’s EDI team, refer to the Provider Resource Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

To Submit Coordination of Benefits (COB) Electronically
To submit COB claims, your practice management system/data entry process and your clearinghouse must be able to:

- Create or forward claims in the full HIPAA standard form at (837) or in a format that contains equivalent information and includes necessary COB fields; and
- Include payment information received from the primary payer’s HIPAA standard electronic remittance advice (ERA) or by converting the primary payer’s paper Explanation of Benefits (EOB) into the standard coding used in an ERA (see section on Converting Information for more details).

Types of COB claims that can be sent electronically:

- Commercial insurance claims where another payer is primary and Missouri Care is secondary; and
- Medicare primary claims when Medicare hasn’t already forwarded us their claim and payment information.

Payment information required for commercial electronic COB claims:

- Adjustment amounts – at both claim level and service line level (if available);
• Adjustment reasons – contractual obligation, deductible, coinsurance, etc.; and
• Primary payer paid amount – at both claim level and service line level (if available).

Payment information required for Medicare primary electronic COB claims:

• Adjustment amounts – at both claim level and service line level (if available);
• Adjustment reasons – contractual obligation, deductible, coinsurance, etc.;
• Medicare paid amount – at both claim level and service line level (if available); and
• Medicare acceptance of assignment.

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires healthcare payers such as Missouri Care, 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. To promote consistency and efficiency for all claims and encounter submissions to Missouri Care, it is Missouri Care’s policy that these requirements also apply to all paper and DDE transactions.

All Providers must submit HIPAA compliant diagnoses codes, ICD-10-CM or its successor, CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) or their successors, and current Revenue Codes and UB Bill Types. Missouri Care will follow all CMS mandates for any future ICD, CPT, HCPCS, Revenue Code or Bill Type changes.

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

Specific Missouri Care requirements for claims and encounter transactions, code sets and SNIP validation are described below. For more information on EDI implementation with Missouri Care, refer to the Missouri Care Companion Guides which may be found on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid/Claims.

Paper Claims Submissions

For a more timely processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties in the Contract. For assistance in creating an EDI process, contact Missouri Care’s EDI team by referring to the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

If permitted under the Contract, and until the Provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the elements and formatting described below:

• Paper claims must only be submitted on 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:
  o The information must be aligned within the data fields and must be:
- On original red print/white paper claim forms;
- Typed. Do not print, hand-write, or stamp any extraneous data on the form;
- In black ink;
- In large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type; 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:

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

Disclosure of Coding Edits
Missouri Care uses claims editing software programs to assist in determining proper coding for Provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and state-specific regulations. These software programs may result in claim edits for specific procedure code combinations.

These claims editing software programs may also result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims-editing software programs by submitting a timely request for reconsideration to Missouri Care. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-Covered Service, and Provider must not bill or collect payment from the Member for such a reduction in payment.

Prompt Payment
By contract with the State of Missouri, Missouri Care follows Missouri State statutes 376.383 and 384 regarding prompt payment.
**Coordination of Benefits (COB)**
As a Medicaid payer, Missouri Care is considered the payer of last resort.

Missouri Care shall coordinate payment for Covered Services in accordance with the terms of a Member’s benefit plan, MO HealthNet rules and regulations, applicable state and federal laws and applicable CMS guidance. If Missouri Care is the secondary insurer, 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 Missouri Care. Missouri Care will coordinate up to the Medicaid allowable amount, so if there is any balance due after receipt of payment from the primary payer, all charges should be submitted to Missouri Care for consideration. For non-FQHC or non-RHC services, if the Member’s responsibility is less than the difference between our allowed amount and what the primary coverage paid, we would only pay the Member responsibility.

The claim must include information verifying the payment amount received from the primary plan as well as a copy of the Explanation of Benefits (EOB). Missouri Care 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 Missouri Care policies and procedures regarding subrogation activity.

**Balance Billing Prohibited**
Providers shall accept payment from Missouri Care for Covered Services provided to Missouri Care Members in accordance with the reimbursement terms outlined in the Contract. Payment made to Providers constitutes payment in full by Missouri Care 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 Contract. An adjustment in payment as a result of Missouri Care’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.

Missouri Code of State Regulations Title 13 CSR 70-4.030 states in part, “When an enrolled Medicaid Provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the Provider accepts the recipient’s Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all the applicable Medicaid rules.”

Missouri Care Members should not be billed or reported to a collection agency for any Covered Services your office provides.

Providers may not bill Missouri Care Members for:
- The difference between actual charges and the contracted reimbursement amount;
- Services denied because of timely filing requirements;
- Services denied due to failure to follow plan procedures;
- Covered Services for which a claim has been returned and denied for lack of information;
- Remaining or denied charges for those services where a contracted Provider fails to notify Missouri Care of a service that required prior authorization. Payment for that service will be denied;
- Covered Services that were not Medically Necessary, in the judgment of Missouri Care, unless prior to rendering the service, the Provider obtains the Member's informed written consent and the Member receives information regarding the Member's financial responsibility for the specific services

Providers may bill Missouri Care Members only:
- When prior to services being rendered to the Member, the Member and Provider enter into a written agreement indicating that neither Missouri Care nor MO HealthNet are the intended payer for the specific item or service but rather the Member accepts the status and liabilities of a private pay patient in accordance with Missouri Code of State Regulations Title 13 CSR 70-4.030. The statement should also include the cost of the non-Covered Service and an assurance that there are no other Covered Services available to the Member. In addition, the disclosure statement must contain the payment arrangements. If the Member will be subject to collection action upon failure to make the required payment, the terms of said action must be included in the disclosure document. A copy of the disclosure form must be kept in the Member's treatment record; or
- When the requirement for written evidence of an agreement between the Member and Provider is not applicable to services provided to a Member who is dually eligible and entitled to both Missouri Care and Medicare Part B medical insurance benefits.

Reimbursement for Non-Participating Providers:
The health plan shall reimburse non-participating providers 90% of the MO HealthNet Fee-for-Service fee schedule rate effective on the date the service was provided. This reimbursement does not apply to the following, which should be paid according to the reimbursement required in Section 2.6 of this contract: local public health agency services; and specialty pediatric hospital services. This reimbursement does not include the following: providers of non-inpatient durable medical equipment; and providers of non-inpatient laboratory services.

Provider-Preventable Conditions (PPCs)
Missouri Care 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.

A Never Event is 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 www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html and include such events as an air embolism, fall and catheter-associated urinary tract infection.

Healthcare Providers may not bill, attempt to collect from, or accept any payment from Missouri Care or the Member for PPCs or hospitalizations and other services related to these non-covered procedures.
**Disputes**
The claims dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Missouri Care in writing within 365 days of the date of denial set forth in the Explanation of Payment (EOP).

When submitting a dispute, the Provider must provide the following information:
- Date(s) of service;
- Member name;
- Member Missouri Care ID number (or MO HealthNet DCN) and/or date of birth;
- Provider name;
- Provider Tax ID/TIN;
- 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 to the address listed in the *Quick Reference Guide* on Missouri Care’s website at [www.wellcare.com/Missouri/Providers/Medicaid](http://www.wellcare.com/Missouri/Providers/Medicaid).

Following the outcome of payment determination, Providers may be afforded further appeal rights. For more information, please refer to *Section 7: Appeals and Grievances*.

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

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

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

To submit a corrected or voided claim via paper:
- For Institutional claims, the Provider must include the original Missouri Care claim number or claim number in which the Provider is requesting to be voided and bill frequency code per industry standards.

  Example:
  Box 4 – Type of Bill: the third character represents the “Frequency Code”
Box 64 – Place the claim number in Box 64

For Professional claims, the Provider must include the original Missouri Care claim number or claim number in which the Provider is requesting to be voided and bill the 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:

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

The correction or void process involves two transactions:

1. The original or claim number in which the Provider is requesting to be voided 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 and will cancel out previous payment 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.

**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 Missouri Care Medical Director on whether the proposed complication merits additional compensation above the usual allowable amount.
• **Admission Examination** – One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.

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

### Multiple Procedures

Payment for multiple procedures is based on:

- 100% of maximum allowable fee for primary surgical procedure;
- 50% of maximum allowable fee for second through the fifth surgical procedure; and
- 25% of maximum allowable fee for all subsequent surgical 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.

### Modifier 51

When multiple procedures are performed at the same session by the same Provider, the primary procedure or service may be reported as listed. The additional procedure(s) or services(s) shall be identified by appending modifier 51 to the additional procedure or service codes(s). Modifier 51 should not be appended to designated “add-on” codes.

### Assistant Surgeon

Assistant Surgeons (modifier 80) are reimbursed consistent with the MO Medicaid Physician Fee Schedule effective on the date the service is provided and consistent with multiple procedure reduction.

### Co-Surgeon

Each Provider will be reimbursed consistent with the MO Medicaid Physician Fee Schedule effective on the date the service is provided. 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.

### Overpayment Recovery

Missouri Care strives for 100% payment accuracy but recognizes that financial overpayments may occur while processing claims. An overpayment can occur due to reasons such as inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-Covered Benefit(s), and other reasons.

Missouri Care will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, Missouri Care will adhere to Missouri Statute 376.384.1(3) which states, “All health carriers shall not request a refund or
offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider.”

Missouri Care, or its designee, will provide a written notice to the provider explaining the reason for identified overpayments and amounts. The notice will include details on how to contact us to request further information and how to refund or dispute the overpayment determination. Given the explicit time frame in the Missouri statute, Missouri Care will adjust the claims for overpayments identified after notice is given with an opportunity to refund – recovery will be handled via offset to future claim payments.

Failure of the Provider to respond within the above time frame will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an informational 835 until the recovery is satisfied, then a financial 835 will be sent that will reflect all the claims associated to the collection of that recovery. In situations where the overpaid balance has aged more than three months and no refund has been received, the Provider may be contacted by WellCare, or its designee, to arrange payment.

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

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

For more information on contacting Provider Services, refer to the Quick Reference Guide, which may be found on the Missouri Care website at: www.wellcare.com/Missouri/Providers/Medicaid.
Section 6: Credentialing

Overview
For purposes of Section 6: Credentialing in this manual, all references to “practitioners” shall include Providers providing health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations.

Credentialing is the process by which the appropriate Missouri Care peer review bodies evaluate the credentials and training qualifications of practitioners.

This review includes (as applicable to practitioner type):
- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner’s ability to provide healthcare;
- Accreditation status, as applicable to non-individuals; and
- Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver.

Practitioners are required to be credentialed prior to being listed as participating network Providers.

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 Missouri Care policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals and ancillary facilities/healthcare delivery organizations are required to be credentialed in order to be network Providers of services to Missouri Care Members.
- Satisfactory site inspection evaluations may be required periodically in accordance with state, federal, and accreditation requirements.
- After the Provider enrollment process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.
Credentialing may be performed directly by Missouri Care or by an entity approved by Missouri Care for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall be required to meet Missouri Care’s criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and Missouri Care 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 missouriproviderrelations@wellcare.com. Upon receipt of a written request, Missouri Care will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.

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

The practitioner may review documentation submitted by him or her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards, subject to any Missouri Care restrictions. Missouri Care, 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 Missouri Care or its designee.

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 Missouri Care, the practitioner has the right to review the information that was submitted in support of his or her application and has the right to correct the erroneous information. Missouri Care will provide written notification to the practitioner of the discrepant information.

Missouri Care’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;
• Missouri Care’s documentation process for receiving the correction information from the Provider; and
• Missouri Care’s review process.

Baseline Criteria
The baseline criteria for practitioners to qualify for Provider network participation are as follows:

- **Credentialing** – Providers must obtain a state Missouri Medicaid Provider ID number through MMAC prior to beginning the credentialing process.
- **License to Practice** – Practitioners must have a current, valid, unrestricted license to practice (as applicable to practitioner type).
- **Drug Enforcement Administration Certificate** – Practitioners must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current CDS or CSR certificate (applicable for MD/DO/DPM/DDS/DMD).
- **Work History** – Practitioners must provide a minimum of five years’ relevant work history as a health professional.
- **Board Certification** – Physicians (MD, DO, DPM) must maintain Board Certification in the specialty being practiced as a Provider for Missouri Care or must have verifiable educational/training from an accredited training program in the specialty requested.
- **Hospital-Admitting Privileges** – Specialist practitioners shall have hospital-admitting privileges at a Missouri Care-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another Missouri Care-participating Provider who has admitting privileges at a Missouri Care-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 Missouri Care Company Plan. Providers are not eligible for participation if such Provider owes money to the Medicaid Program or if the Office of the Attorney General has an active fraud investigation involving the Provider. Existing Providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with Missouri Care policy and procedure.
- **New Providers** – All healthcare Providers that are covered entities under HIPAA must obtain a National Provider Identifier (NPI) to participate in Missouri Care’s network.

**Liability Insurance**
Missouri Care Plan Providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits as indicated below, unless otherwise agreed by Missouri Care in writing:

- $1,000,000/$3,000,000 per Provider

Providers must furnish copies of current professional liability insurance certificate to Missouri Care, concurrent with expiration.
Site Inspection Evaluation (SIE)

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

- Office-site criteria:
  - Physical accessibility;
  - Physical appearance; and
  - Adequacy of waiting room and examination room space;
- Medical/treatment record keeping criteria;
- Evidence that the health plan has determined that the following documents are posted in the Provider's waiting room/reception area:
  - Office Hours; and
  - Member Rights and Responsibilities.

SIEs are conducted for:

- Unaccredited facilities who cannot provide a state or CMS review or certification
- When a complaint is received relative to office site criteria.

Although CMS or State review or certification does not serve as accreditation of an institution, in the case of non-accredited institutions, a CMS or State review may be substituted in lieu to the required site visit. The institution/facility may provide evidence in the form of a report from the state or CMS confirming the review was performed and indicating that the institution/facility met standards; however, a letter from CMS showing that the facility was reviewed and indicating that it passed inspection may also be used in lieu of the survey report. Review of the criteria used by the state or CMS will be made to ensure the criteria used by CMS or the state is acceptable to meet all elements of Missouri Care’s initial assessment criteria.

In states where initial SIEs are not required 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 on-site review.

Covering Physicians

PCPs in a solo practice must have a covering physician who also participates with, or is credentialed with, Missouri Care.

Allied Health Professionals

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

Dependent AHPs include the following, and are required to provide collaborative practice information to Missouri Care that includes a supervising/collaborating physician who also participates with, or is credentialed with, Missouri Care:

- Advanced Registered Nurse Practitioners (ARNP);
- Certified Nurse Midwife (CNM);

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

- Licensed clinical social worker;
- Licensed master social worker;
• Licensed professional counselor;
• Licensed marriage and family therapist;
• Physical therapist;
• Occupational therapist;
• Audiologist; and
• Speech/language therapist/pathologist.

Provisionally Licensed Psychologists, Professional Counselors and Social Workers
Credentialing of provisionally licensed psychologists, professional counselors and social workers is permitted. They are expected to follow all requirements of their respective licensure laws/rules. Missouri Care requires that the supervisors of these provisionally licensed individuals be credentialed as well. Missouri Care also requires that provisionally licensed individuals submit a copy of their supervision plan that was submitted to their respective licensure board. Provisionally licensed mental health practitioners shall be recredentialed annually.

Ancillary Healthcare Delivery Organizations
Ancillary and organizational applicants, as defined by NCQA criteria, must complete an application and, as applicable, undergo an SIE (as applicable). Missouri Care is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage prior to accepting the applicant as a Missouri Care Provider.

Re-Credentialing
In accordance with regulatory, accreditation and Missouri Care policy and procedure, re-credentialing is required at least once every three years.

Updated Documentation
In accordance with contractual requirements, Providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to Provider type) to Missouri Care prior to or concurrent with expiration.

Office of Inspector General Medicare/Medicaid Sanctions Report
Monthly Missouri Care or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most currently 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 Missouri Care policies and procedures.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials
On a monthly basis, Missouri Care 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 Missouri Care Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with Missouri Care policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Missouri Care 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**

Missouri Care may immediately suspend, pending investigation, the participation status of a participating Provider who, in the sole discretion 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.

Missouri Care has a Participating Provider Dispute Resolution Peer Review Panel Process in the event Missouri Care 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 2 levels. All disputes in connection with the actions listed below are referred to a first-level Peer Review Panel consisting of at least 3 qualified individuals, of whom at least 1 is a participating Provider and a clinical peer of the practitioner who filed the dispute.

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

The following actions by Missouri Care entitle the affected practitioner to the Provider Dispute Resolution Peer Review Panel Process:

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

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

The practitioner has a period of up to 30 days in which to file a written request via recorded or certified return-receipt mail to access the Dispute Resolution Peer Review Panel Process. Upon timely receipt of the request, the medical director or his or her designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing.

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

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

In the event the findings of the first-level Panel hearing are adverse to the practitioner, the practitioner may access the second-level Peer Review Panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first-level Peer Review Panel.

Within 10 calendar days of the request for a second-level Peer Review Panel hearing, the medical director or his or her designee shall notify the practitioner of the date, time and access number for the second level Peer Review Panel hearing.

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

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

**Delegated Entities**

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

Provider Complaints and Appeals
Missouri Care evaluates and processes complaints and appeals filed by participating and non-participating health professionals according to applicable State of Missouri and federal statutes, regulations, contract and policies. All medical issues are reviewed by the chief medical officer or his or her designee.

An Adverse Benefit Determination is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for services; or the failure of Missouri Care to act within the time frames specified.

A complaint is a verbal or written expression by a Provider, which indicates dissatisfaction or dispute with Missouri Care policy, procedure, claims (reimbursement amount, processing time, procedures, etc.) or any aspect of Missouri Care functions other than an action. All complaints will be logged and tracked whether received by phone, in person or in writing.

An appeal is the mechanism that allows Providers the right to appeal Adverse Benefit Determinations of Missouri Care. Appeals must be submitted in writing. All expressions of dissatisfaction resulting from receipt of a claim or authorization denial or a claims dispute resolution are automatically classified as an appeal.

Provider Complaints and Appeals Procedures
All complaints and appeals will be filed directly by mailing the information to:

Missouri Care
4205 Philips Farm Road
Suite 100
Columbia, MO 65201

Providers may file a verbal or written complaint or a written appeal within 90 days, or within a contractually specified time frame, of the incident or Adverse Benefit Determination/denial that resulted in the complaint or appeal. Complaints will be resolved within 30 calendar days of receipt of the complaint at Missouri Care. At the time of the complaint decision, the Provider will receive written notification of their right to file an appeal. If the Provider is dissatisfied with the complaint resolution, the Provider or Provider’s representative may file an appeal in writing within 90 calendar days of the complaint resolution. The appeal process will include an opportunity for the Provider or their representative to present their case in person.

Missouri Care will reach a final decision on an appeal within 30 calendar days of receipt of the appeal, with extensions possible if approved by the state agency. The Provider may request an expedited review of the appeal if the standard time frame could seriously jeopardize the Member’s life, physical or mental health or the Member’s ability to regain maximum function. All expedited appeals are treated as Member appeals. The expedited review will be resolved no later than 72 hours after the request or as expeditiously as the Member’s physical or mental health requires.
Member Grievances and Appeals
Missouri Care evaluates and processes grievances and appeals filed by Members according to applicable State of Missouri and federal statutes, regulations, contracts and policies. A Member can file grievances in regard to any aspect of service including those related to cultural sensitivity or sexual harassment. In no instance will a Member be subject to any punitive action, including charges, for using the grievance and appeal process.

A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination as defined above. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Member’s rights. An appeal is a request for review of an Adverse Benefit Determination.

Member Grievance Procedure
All grievances directed at a Provider for the following issues related to the office/location are reported to Missouri Care’s Provider Services Department: physical accessibility, physical appearance, adequacy of waiting/examination room space, availability of appointments, and adequacy of treatment record keeping. Any such grievance can be followed by a site visit to the Provider’s office for review. An action plan will be implemented if deficiencies are noted.

- A Member may file a grievance either verbally or in writing.
- All grievances will be acknowledged in writing within 10 business days of filing.
- Written notification of the disposition of the grievance will not exceed 30 calendar days from the filing date or as expeditiously as the Member’s health condition requires.

To file a grievance, a Member can call Missouri Care at 1-800-322-6027 and tell them they want to file a grievance. TTY users can call 711 or 1-800-735-2966. If the Member speaks another language, they can ask for an interpreter at no cost to the Member.

Member Appeal Procedure and Rights to a State Fair Hearing
Member Appeal Procedure
A Member may file an appeal within 90 calendar days from the date on Missouri Care’s notice of Adverse Benefit Determination. With the Member’s written consent, a Provider or other authorized representative may file an appeal on behalf of a Member. The Member can present his or her case in person. The Member can represent himself or herself, or receive help from a relative, friend, or from anyone else the Member chooses. The Member may be represented by an attorney.

A Member can also file an appeal in writing with Missouri Care if:

- Missouri Care fails to act within required time frames for getting a service;
- Missouri Care fails to make a grievance decision within 30 days of receipt of request;
- Missouri Care fails to make an expedited decision within 3 days of receipt of request; or
- Missouri Care fails to make an appeal decision within 45 days of receipt of request.
To file a verbal appeal, a Member can call Missouri Care at 1-800-322-6027. TTY users can call 711 or 1-800-735-2966. If the Member speaks another language, an interpreter will be made available at no cost to the Member.

Verbal requests must be followed by a written, signed appeal, unless expedited review is requested. For expedited appeals, Providers may act as the Member’s authorized representative with written consent by the Member. All appeals will be acknowledged in writing within 10 business days after receipt.

The time frame for resolution of the appeal, and written notification of the resolution, will not exceed 30 calendar days from the date of the receipt of the appeal, or will be as expedited as the Member’s health condition requires.

Members may file a written appeal to:

**Missouri Care**
**Appeals Department**
**4205 Phillips Farm Road**
**Suite 100**
**Columbia, MO 65201**

*Member Rights to a State Fair Hearing*
To ask for a State Fair Hearing, a Member can call 1-800-392-2161. TTY users, call 711 or 1-800-735-2966. If the Member speaks another language, an interpreter will be made available at no cost to the Member. Or a written request can be submitted to:

**MO HealthNet Division**
**Participant Services Unit**
**P.O. Box 6500**
**Jefferson City, MO 65102**

The hearing is informal. The Member can present his or her case in person. The Member can represent himself or herself, or receive help from a relative, friend, or from anyone else the Member chooses. The Member may be represented by an attorney. The Member has one hundred twenty (120) calendar days from the health plan’s resolution of appeal to request a State Fair Hearing.

The state agency must reach its decision within the specified time frames:
- For standard resolution: within 90 calendar days from the state agency’s receipt of a State Fair Hearing request.
- For expedited resolution: within three business days from the state agency’s receipt of a State Fair Hearing request for a denial of a service that meets the criteria for an expedited appeal process, but was not resolved using the health plan’s expedited appeal time frames, or was resolved wholly or partially adversely to the Member using the health plan’s expedited appeal time frames.

A Member may continue to receive services during the appeals/hearing process under the following circumstances:
• As used in this section, “timely” filing means filing in writing on or before the latter of the following:
  o Within 10 calendar days of the mailing of the notice of action; or
  o The intended effective date of the proposed action.
• The Member’s benefits shall be continued if the Member or the Provider files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized Provider; the original period covered by the original authorization has not expired; and the Member requests extension of the benefits.
• If the Member requests benefits to be continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:
  o The Member withdraws the appeal;
  o 10 calendar days pass after Missouri Care mails the notice, providing the resolution of the appeal against the Member, unless the Member, within the 10 calendar day time frame, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;
  o A State Fair Hearing officer issues a hearing decision adverse to the Member; and
  o 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, that is, upholds Missouri Care’s action, Missouri Care may recover the cost of the services furnished to the Member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. The Member is informed that he/she can be financially liable for the services that were rendered during this process.
Section 8: Compliance
Missouri Care Compliance Program

Overview
Missouri Care’s Corporate Ethics and Compliance Program, as may be amended from time to time, includes information regarding Missouri Care's policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by Missouri Care, Missouri Care employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All Providers, including Provider’s employees and Provider’s subcontractors and their employees, are required to comply with Missouri Care Compliance Program requirements. Missouri Care’s compliance-related training requirements include, but are not limited to, the following initiatives:

- HIPAA Privacy and Security Training:
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA.
  - Training includes, but is not limited to, discussion on:
    - Proper 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 FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.);
    - Obligations of the Provider, including Provider employees and Provider subcontractors and their employees, to have appropriate policies and procedures to address FWA;
    - Process for reporting suspected FWA;
    - Protections for employees and subcontractors who report suspected FWA; and
    - Types of FWA that can occur.

- Cultural Competency Training:
  - Develop programs to educate and identify the diverse cultural and linguistic needs of the Members 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 Missouri Care any suspected fraud, waste or abuse, misconduct or criminal acts by Missouri Care, or any Provider, including Provider employees and/or Provider subcontractors, or by Missouri Care Members. Reports may be made anonymously through the Missouri Care FWA Hotline at 1-866-678-8355.

Details of the Corporate Ethics and Compliance Program may be found on Missouri Care’s website at [www.wellcare.com/Missouri/Corporate/Compliance](http://www.wellcare.com/Missouri/Corporate/Compliance).
Provider Education and Outreach

Providers may:
- Display state-approved health-plan 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 Missouri Care, or any other entity; and
- Assisting with health plan enrollment.

International Classification of Diseases (ICD)

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


Information on the ICD-10 transition and codes can also be found at www.wellcare.com/Missouri/Providers/ICD10-Compliance.

Code of Conduct and Business Ethics

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

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

Missouri Care is committed to the prevention, detection, and reporting of health care fraud, waste and abuse according to applicable federal and state statutory, regulatory, and contractual requirements. Missouri Care has developed an aggressive, proactive Fraud, Waste and Abuse Program designed to collect, analyze and evaluate data in order to identify suspected fraud, waste and abuse. Detection tools have been developed to identify patterns of healthcare service use, including overutilization, unbundling, up-coding, misuse of modifiers, and other common schemes.

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

In addition, Providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud, waste 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.

To report suspected fraud, waste and abuse, please refer to your Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid, or call our confidential and toll-free Missouri Care compliance hotline at 1-866-678-8355. Details of the Corporate Ethics and Compliance Program, and how to contact the Missouri Care fraud hotline, may be found on Missouri Care’s website at www.wellcare.com/Missouri/Corporate/Compliance.

Confidentiality of Member Information and Release of Records

Medical records must be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member or his/her case must 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 must be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of Members’ medical records and other Protected Health Information (PHI), and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures must include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

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. Employees who have
access to Member records and other confidential information are required to sign a Confidentiality Statement.

Some examples of confidential information include:
- Medical records;
- Communication between a Member and a Provider regarding the Member’s medical care and treatment;
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
- Any communication with other clinical persons involved in the Member’s health, medical and 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 Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

The NPP informs the Member of her or his rights under HIPAA and how the Provider and/or Missouri Care may use or disclose the Member’s PHI. HIPAA regulations require each covered entity, such as healthcare Providers, to provide a NPP to each new patient or Member.

Written consent of the Member is required for the transmission of the clinical and medical record information of a former enrolled Member to any physician not connected with Missouri Care. The extent of clinical or medical record information to be released in each instance shall be based upon tests of Medical Necessity and a “need to know” on the part of the practitioner or facility requesting the information.

**Disclosure of Information**
Periodically, Members may inquire as to the operational and financial nature of their health plan. Missouri Care will provide that information to any Member upon request. Members can request the above information verbally or in writing.

For more information on how to request this information, Members may contact Missouri Care’s Provider Services using the toll-free telephone number found on the Member’s ID card. Providers may contact Missouri Care’s Provider Services by referring to the **Quick Reference Guide** on Missouri Care’s website at [www.wellcare.com/Missouri/Providers/Medicaid](http://www.wellcare.com/Missouri/Providers/Medicaid).

**Cultural Competency Program and Plan**

The purpose of the Cultural Competency Program is to ensure that Missouri Care 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, Missouri Care is committed to having our Providers fully recognize and care for the culturally diverse needs of the Members they serve.

The objectives of the Cultural Competency Program are to:
- Identify Members who have potential cultural or linguistic barriers for which alternative communication methods are needed;
Use culturally sensitive and appropriate educational materials based on the Member’s race, ethnicity, and primary language spoken;

Make resources available to address the unique language barriers and communication barriers that exist in the population;

Help Providers care for and recognize the culturally diverse needs of the population;

Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served; and

Decrease healthcare disparities in the minority populations we serve.

Culturally and Linguistically Appropriate Services (CLAS) are healthcare services provided that are respectful of and responsive to cultural and linguistic needs. The delivery of culturally competent healthcare and services requires that healthcare Providers and/or their staff possess a set of attitudes, skills, behaviors, and policies that enable the organization and staff to work effectively in cross-cultural situations.

The components of Missouri Care’s Cultural Competency Program include:

- **Data Analysis** – Missouri Care analyzes data on the populations in each region we serve for the purpose of learning about that region’s cultural and linguistic needs, as well as any health disparities specific to that region. Such analyses are performed at the time we enter 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 healthcare needs of the population by identifying the diagnostic categories that are the most prevalent;
  - Member requests for assistance, or Member grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle;
  - Data on race, ethnicity and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers.

- **Community-Based Support**: Our success requires linking with other groups that share the same goals.
  
  - WellCare reaches out to community-based organizations that support racial and ethnic minorities, and the disabled, to ensure that existing community resources for Members who have special needs are used to their full potential. The goal is
to coordinate the deployment of both community and 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.

- Missouri Care develops and maintains grassroots sponsorships that enhance our effort to reach low-income communities. We also provide opportunities for building meaningful relationships that benefit all Members of the communities. These sponsorships are coordinated with Providers, community health fairs and public events.

- Diversity and Language Abilities of Missouri Care: WellCare recruits diverse talented staff to work in all levels of the organization. We do not discriminate with regard to race, national origin, sex, age, disability, religion or ethnic background when hiring staff.

  - Missouri Care 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 our Customer Service representatives are bilingual. Spanish is the most common translation required. Whenever possible, we will also distinguish place of origin of our 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 we enroll significant numbers of Members who speak languages other than English or Spanish, Missouri Care seeks to recruit staff Members who are bilingual in English plus one of those other languages. We do this even if the particular population is not of a size that triggers state agency mandates.

- Diversity of Provider Network

  - Providers are inventoried for their language abilities. This information is made available in the Provider Directory so that Members can choose a Provider that speaks their primary language.

  - Providers are recruited to ensure a diverse selection of Providers to care for the population served.

- Linguistic Services

  - Providers will identify Members who have potential linguistic barriers for which alternative communication methods are needed and will contact Missouri Care to arrange appropriate assistance.

  - Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service Department.
Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency, and sign language for the hearing impaired. These services are provided by vendors with such expertise and coordinated by Missouri Care’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. Missouri Care’s Customer Service Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY number can be found on the Member identification card.

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

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

For more information about the Cultural Competency Program, registered provider portal users may access the Cultural Competency training on Missouri Care’s website at [www.wellcare.com/Missouri/Providers](http://www.wellcare.com/Missouri/Providers). A paper copy, at no charge, may be obtained upon request by contacting Provider Services or your Provider Relations representative.

**Cultural Competency Survey**
Providers may access the Cultural Competency Survey on WellCare’s website at [www.wellcare.com/Missouri/Providers](http://www.wellcare.com/Missouri/Providers).
Section 9: Delegated Entities

Overview
Missouri Care may, by written contract, delegate certain functions under Missouri Care’s contracts with CMS and/or applicable state governmental agencies. These functions include, but are not limited to, contracts for administration and management services, marketing, utilization management, quality assurance, care management, disease management, claims processing, claims payment, credentialing, network management, Provider claim appeals, customer service, enrollment, disenrollment, billing and sales, adjudicating Medicare organization determinations, and appeals and grievances (the Delegated Services). Missouri Care may delegate all or a portion of these activities to another entity (a Delegated Entity).

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

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

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

Missouri Care monitors compliance through the delegation oversight process and the Delegation Oversight Committee through the following activities:

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

Overview
Missouri Care 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.

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

As stated in the Member Administrative Guidelines in Section 2, eligibility can change at any time and not all behavioral health services are billable to Missouri Care. Please refer to the MO HealthNet Behavioral Health Provider Manual for ME Code (medical eligibility) definitions and restrictions. The ME code should be verified before rendering services to the Member.

Some behavioral health services may require prior authorization, including all services provided by non-participating providers. Missouri Care uses LOCUS/CALOCUS criteria for mental health and substance abuse. The criteria are well-known and nationally accepted guidelines for assessing level of care, including initial determinations, continued stays and to support the discharge planning process.

For information regarding benefits, exclusions and authorization requirements, or in the event you need to contact Missouri Care’s Provider Services for a referral to a behavioral health Provider, refer to the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

Billing Guidelines
Missouri Care adheres to MO HealthNet Provider billing guidelines unless otherwise stated in this manual. Please refer to Section 13 Benefits and Limitations in the MO HealthNet Behavioral Health Provider Manual for information on the following subjects:

- Adequate Documentation
- Living Will and Advance Directives
- Restriction of services under licensure and scope of practice
- Billable hour and time-based service limitations
- Appropriate usage of specialty modifiers for claims filing (Note: If place of service 12 for home is used, then the U8 modifier must be submitted in the first position and the specialty modifier in the second position when submitting claims to Missouri Care.)

Behavioral Health Program
Missouri Care encourages community-based services and Member treatment at the least restrictive level of care whenever possible.

Prior authorization is required for certain outpatient services including, but not limited to, intensive outpatient programs, partial hospitalization programs, residential treatment programs and inpatient hospital services. Most outpatient behavioral health services provided by participating Providers do not require a service authorization.
For psychiatric/behavioral emergency stabilization services, notification must be made within 24 hours or, on weekends or holidays, the next business day. For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, Missouri Care uses LOCUS/CALOCUS. If the Member scores less than an inpatient level of care on the LOCUS/CALOCUS but the services recommended are not available, Missouri Care will continue to authorize inpatient care. In the event of disagreement, Missouri Care will provide full detail of its scoring of the LOCUS/CALOCUS to the Provider of service.

Inpatient initial, concurrent and discharge reviews are conducted by faxing supporting clinical documentation to 1-866-946-2052. For information regarding authorization requirements, please refer to the Quick Reference Guide on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Medicaid.

For children within the Category of Aid 4 group with only a behavioral health or substance abuse diagnosis (no physical health diagnosis), Missouri Care isn’t responsible for the following Medically Necessary behavioral health and substance abuse services:

- Inpatient Behavioral Health and Substance Abuse Services
- Outpatient Behavioral Health and Substance Abuse Services
- Comprehensive Community Support Services

**Clinical Practice Guidelines**

Missouri Care adopts validated evidence-based CPGs and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede CPGs, 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 CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the Quality Improvement Committee. CPGs, to include Preventive Health guidelines, may be found on Missouri Care’s website at www.wellcare.com/Missouri/Providers/Clinical-Guidelines/CPGs.

**Continuity and Coordination of Care between Medical and Behavioral Healthcare Providers**

Continuity and coordination of care between physical and behavioral health is an important aspect in the delivery of quality healthcare, as behavioral and medical disorders can interact to affect an individual’s health. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health Providers may provide physical healthcare services if and when they are licensed to do so within the scope of their practice.

Behavioral Providers are responsible for completing the Coordination of Care Form at the time of initiation of treatment and updating as necessary to reflect significant changes in the Member’s treatment plan or medications. The completed form should be sent to the Member’s PCP for inclusion in the medical record. Providers are required to use the ICD-10 or current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) when assessing the Member for behavioral health services and documenting the diagnosis and assessment/outcome information in the Member’s medical record.
Communication with the PCP should occur more frequently if clinically indicated. Missouri Care encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization. Missouri Care recommends faxing discharge information, or a letter summarizing the hospital stay, to the PCP.

We strongly encourage open communication between PCPs and behavioral health Providers. If a Member’s medical or behavioral condition changes, Missouri Care 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.

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

**Responsibilities of Behavioral Health Providers**

Missouri Care monitors Providers against access standards to ensure Members can obtain needed clinical services within the acceptable appointment 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 Missouri Care.

<table>
<thead>
<tr>
<th>Type Of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Life-threatening Emergency</td>
<td>within 6 hours or refer to the ER</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>within 24 hours</td>
</tr>
<tr>
<td>Routine Visit with Symptoms</td>
<td>within 5 business days</td>
</tr>
<tr>
<td>Routine Visit with no Symptoms</td>
<td>within 10 business days</td>
</tr>
<tr>
<td>Follow-up to BH/Substance Abuse Hospital Stay</td>
<td>within 7 calendar days from discharge date</td>
</tr>
<tr>
<td>Follow-up visits to initial routine care appointments</td>
<td>within 30 calendar days to evaluate progress and changes that have taken place</td>
</tr>
</tbody>
</table>

All Members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place and name of the Provider to be seen. The outpatient treatment must occur within seven calendar days from the date of discharge. The day of discharge counts as the first day.

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 twenty-four (24) hours a day. The Member may access the behavioral crisis line by calling **1-800-322-6027**.

Behavioral health and substance abuse Providers are required to complete a health status screen, at the initial point of contact and as part of the re-assessment process for Members in
treatment. Members with physical health conditions (as indicated by the screen) should be referred to their PCP for evaluation and treatment of the physical health condition.

For additional information about Missouri Care’s Behavioral Health Utilization Management, Care Management and Disease Management Programs, including how to refer a Member for these services, please see Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM).

Community Outreach Advisory Council on Health (COACH)
Missouri Care values the input of our behavioral health Members, advocates, and Providers. The COACH council has been established in order to assist with ensuring Missouri Care’s services and programs meet the needs and expectations of the Member and Provider community. The COACH meets on a quarterly basis and provides recommendations to the Quality Improvement Committee. We encourage our behavioral health Providers to participate in the council. Contact the Manager of Community Relations at 1-800-322-6027 if you are interested in participating in the council.
Section 11: Definitions

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

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

“Adverse Benefit Determination” means, pursuant to 42 CFR 438.400(b):
- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the state
- The failure of Missouri Care to act within the time frames provided in §438.408(b)
- For a resident of a rural area with only one managed care entity, the denial of a Medicaid enrollee’s request to exercise his or her right under §438.52(b)(2)(ii) to obtain services outside the network

“Appeal” means a formal request from an enrollee to seek a review of an action taken by Missouri Care.

“Appeals Process” means the overall process that includes appeals at the contractor level and access to the State Fair Hearing process (the State’s Administrative Law Hearing).

“Authorization” means an approval request for payment of services. An authorization is provided only after Missouri Care agrees the treatment is necessary.

“Benefits” or “Benefit Plan” means the healthcare services for which Missouri Care has agreed to provide, arrange, and be held fiscally responsible.

“Business Days” means Monday through Friday (8 a.m. to 5 p.m., excluding state holidays).

“Calendar Days” means all 7 days of the week.

“Centers for Medicare & Medicaid Services (CMS)” means the agency within the U.S. Department of Health and Human Services with responsibility for Medicare, Medicaid and the State Children’s Health Insurance Program.

“Claim” means a bill for services, a line item of services, or all services for one recipient within a bill.

“Claim Adjustment” means a claim that has been incorrectly paid, incorrectly submitted or, as the result of an updated payment policy, the payment amount can be changed.

“Clean Claim” means a claim received by Missouri Care for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further
information, adjustment, or alteration by the Provider of the services in order to be processed and paid by Missouri Care. The following exceptions apply to this definition:
- A claim for payment of expenses incurred during a period of time for which premiums are delinquent
- A claim for which fraud is suspected
- A claim for which a third-party resource should be responsible

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

“Co-payment or Co-pay” means the part of the cost-sharing requirement for Members in which a fixed monetary amount is paid for certain services/items received from the contractor’s Providers.

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

“Covered Services” means those Medically Necessary healthcare services provided to Members, the payment or indemnification of which is covered by Missouri Care.

“Disenrollment” means the removal of a Member from participation in Missouri Care’s plan but not necessarily from the Medicaid Program.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program” means a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental deficiencies in Members younger than 21 years of age, and healthcare, treatment, and other measures to correct or ameliorate any deficiencies and chronic conditions discovered.

“Emergency Medical Condition” means 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 the absence of immediate medical attention to result in the following:
- 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 of bodily functions
- serious dysfunction of any bodily organ or part

An emergency medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

In addition to the conditions identified under federal law and the state of Missouri, Missouri Care considers the following symptoms to also be emergent in nature:
- serious harm to self or others due to an alcohol or drug abuse emergency
- injury to self or bodily harm to others
- with respect to a pregnant woman having contractions:
  - that there is not adequate time to effect a safe transfer to another hospital before delivery; and/or
• that transfer may pose a threat to the health or safety of the woman or the unborn child

“Emergency Services and Care” means covered inpatient and outpatient services furnished by a qualified Provider needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.

“Encounter” means a distinct set of healthcare services provided to a Medicaid Member enrolled with Missouri Care on the dates that the services were delivered.

“Encounter Data” means:
- All data captured during the course of a single healthcare encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Member receiving services during the encounter
- The identification of the Member receiving and the Provider(s) delivering the healthcare services during the single encounter
- A unique, i.e., unduplicated, identifier for the single encounter

“Grievance” means an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to:
- The quality of care or services provided
- Aspects of interpersonal relationships such as rudeness of a Provider or employee
- Failure to respect the Member's rights

“Healthcare” means care, services, or supplies related to the health of an individual. Healthcare includes, but is not limited to, the following:
- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body
- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription

“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.
“Long-Term Acute Care (LTAC) Hospital” means care facilities include nursing homes, skilled nursing facilities, psychiatric residential treatment facilities and other facilities that provide long-term, non-acute care.

“Medical Necessity” or “Medically Necessary” means services that are sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community in which the services are rendered. Services shall be furnished in the most appropriate setting. A service shall be considered Medically Necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health condition or injury; (2) is necessary for the Member to achieve age-appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the Member to attain, maintain, or regain functional capacity.

“Member” means a Medicaid recipient who is currently enrolled in an MCO plan.

“Member Expenses” means co-payments, coinsurance, deductibles or other cost-share amounts, if any, that a Member is required to pay for Covered Services under a benefit plan.

“Members/Individuals with Special Health Care Needs” means 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.

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

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

“Periodicity Schedule” means the schedule that defines age-appropriate services and time frames for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Program.

“Post-Stabilization Services” means Covered Services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member’s condition.

“Preventive Services” means services provided by a physician or other licensed health practitioner within the scope of his or her practice under state law to:

- Prevent disease, disability, and other health conditions or their progression;
- Treat potential secondary conditions before they happen or at an early remediably stage;
- Prolong life; and
- Promote physical and mental health and efficiency.

“Primary Care” means all healthcare services and laboratory services, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of
referrals to specialty Providers, required for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

“Primary Care Provider” (PCP) means a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioners who, within the scope of practice and in accordance with state certification licensure requirements, standards, and practices, is responsible for providing all required primary care services to Members. A PCP shall include general/family practitioners, pediatricians, internists, physician’s assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with licensure requirements.

“Prior Authorization” means the act of authorizing specific services before they are rendered. (Also known as “pre-authorization” or “prior approval”.)

“Proposed Action” means the proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of Missouri Care to act within the specified time frames.

“Provider” means any person (including physicians or other health care professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Missouri to provide healthcare services that has contracted with Missouri Care to provide healthcare services to Members.

“Provider Complaint” means a written expression by a Provider that indicates dissatisfaction or dispute with the contractor’s policies, procedures, or any aspect of a contractor’s administrative functions.

“Provider Contract” means any written contract between the contractor and a Provider that requires the Provider to perform specific parts of the contractor’s obligations for the provision of healthcare services under this contract.

“Referral” means a request by a PCP for a Member to be evaluated and/or treated by a specialty physician.

“(Claims) Reprocessing” means, upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims.

“Routine Care” means that treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physician’s office) or by the patient.

“Service” means healthcare, treatment, a procedure, supply, item or equipment.
“Urgent Care” means Medically Necessary treatment for an injury, illness, or another type of condition (usually not life-threatening) which should be treated within 24 hours.
Section 12: Missouri Care Resources

Missouri Care’s Home Page  
www.wellcare.com/missouri

Provider Home Page  
www.wellcare.com/Missouri/Providers

Quick Reference Guide  
www.wellcare.com/Missouri/Providers/Medicaid

Provider Orientation  
www.missouricare.com/login/provider
You must be a registered user of Missouri Care’s secure provider portal to access.

Forms and Documents  
www.wellcare.com/Missouri/Providers/Medicaid/Forms

Clinical Practice Guidelines  
www.wellcare.com/Missouri/Providers/Clinical-Guidelines/CPGs

Clinical Coverage Guidelines  
www.wellcare.com/Missouri/Providers/Clinical-Guidelines/CCGs

Claims Information  
www.wellcare.com/Missouri/Providers/Medicaid/Claims

Job Aids and Resource Guides  
www.wellcare.com/Missouri/Providers/Medicaid
Quality care is a team effort. Thank you for playing a starring role!

www.wellcare.com/Missouri