Behavioral Health 2013 Provider Orientation
Medicare Markets
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About our company

• WellCare comprises a family of health plans that works with physicians and other health care professionals to provide our members with quality care

• We are among the largest Medicaid and Medicare-only contractors in the nation with approximately 2.7 million members as of December 31, 2012

• The company began operations in 1985. WellCare has more than 222,000 contracted health care providers and more than 73,000 pharmacies.

• WellCare serves approximately 272,000 Medicare Advantage Members and 772,000 Prescription Drug Plan (PDP) members.

• WellCare has over 20 years of experience and is the leading provider of government-sponsored health plans such as Medicare, Medicaid, State Children’s Health Insurance Programs (CHIPs) and others
About WellCare

- WellCare Health Plans, Inc. (WellCare) is a family of health plans that works with physicians and other healthcare professionals to provide our members with quality care. The following companies are covered in this orientation:

  - WellCare of Arizona
  - WellCare of Connecticut
  - WellCare of Florida
  - WellCare of Georgia
  - WellCare of Illinois
  - WellCare of Louisiana
  - WellCare of Missouri
  - WellCare Health Plan of New Jersey
  - WellCare of New York
  - WellCare of Ohio
  - WellCare of Texas
As of June 30, 2013

<table>
<thead>
<tr>
<th>State</th>
<th>Began Operations</th>
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<tbody>
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<td>Florida</td>
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<td>South Carolina</td>
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WellCare's Arizona Medicare Presence:

- Approximately 4,000 Medicare Advantage members.
- Approximately 14,000 Medicare Prescription Drug Plan members.
- All Medicare plans offer a Pay-for-Performance program that promotes the timely completion of health care and preventive services, and improves the quality of care for eligible members.
- Medicare PDP available statewide.

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<thead>
<tr>
<th>Medicare Advantage &amp; PDP plans available</th>
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WellCare’s Connecticut Medicare Presence:

- Approximately 7,000 Medicare Advantage members.
- Approximately 13,000 Medicare Prescription Drug Plan members.
- All Medicare plans offer Quality Incentive programs designed to improve the quality of care and outcomes for eligible members.
- All Plans Offer:
  - Preventative dental
  - Vision
  - Over-the-counter medication credits
- Medicare PDP available statewide.
WellCare’s Florida Medicare Presence:

• Approximately 79,000 Medicare Advantage members.
• Approximately 39,000 Medicare Prescription Drug Plan members.
• *Includes approximately 14,000 dual-eligible members.
• Approximately one-third of WellCare’s Medicare members in Florida are also eligible for Medicaid.
• All Medicare plans offer a Pay-for-Performance program that promotes the timely completion of health care and preventive services, and improves the quality of care for eligible members.
• Medicare PDP available statewide.
WellCare’s Georgia Medicare Presence:

- Approximately 25,000 Medicare Advantage members.
- Approximately 34,000 Medicare Prescription Drug Plan members.
- All Medicare plans offer a Pay-for-Performance program that promotes the timely completion of health care and preventive services, and improves the quality of care for eligible members.
- All Plans Offer:
  - Preventative dental
  - Vision
  - Over-the-counter medication credits
- Medicare PDP available statewide.
WellCare’s Kentucky Medicare Presence:

- Approximately 2,000 Medicare Advantage members.
- Approximately 13,000 Medicare Prescription Drug Plan members.
- All Plans Offer:
  - Preventative dental
  - Vision
  - Over-the-counter medication credits
- Medicare PDP available statewide.
Harmony’s Illinois Medicare Presence:

- Approximately 14,000 Medicare Advantage members.
- Approximately 23,000 Medicare Prescription Drug Plan members.
- All Medicare plans offer a Pay-for-Performance program that promotes the timely completion of health care and preventive services, and improves the quality of care for eligible members.
- All Plans Offer:
  - Preventative Dental
  - Vision
  - Silver Sneakers (Gym membership)
- Medicare PDP available statewide.

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WellCare’s Missouri Medicare Presence:

- Approximately 4,500 Medicare Advantage members.
- Offers Medicare Prescription Drug Plans.
- All Medicare plans promote the timely completion of health care and preventive services, and improve the quality of care for eligible members.
- All Plans offer
  - Preventative Dental
  - Vision
  - OTC Prescriptions
  - Transportation
WellCare serves approximately 15,500 Medicare members across the state.

WellCare’s New Jersey Medicare Presence:

- Approximately 1,500 Medicare Advantage members.
- Approximately 14,000 Medicare Prescription Drug Plan members.
- All Medicare plans offer a Pay-for-Performance program that promotes the timely completion of health care and preventive services, and improves the quality of care for eligible members.
  - All Plans Offer:
    - Vision
    - Over-the-counter medication credits
    - Silver Sneakers senior fitness program
    - Medicare PDP available statewide.
WellCare's New York Medicare Presence:

- Approximately 41,000 Medicare Advantage members.
- Approximately 40,000 Medicare Prescription Drug Plan members.
- All Medicare plans offer a Pay-for-Performance program that promotes the timely completion of health care and preventive services, and improves the quality of care for eligible members.
- All Plans Offer:
  - Preventative dental
  - Vision
  - Over-the-counter medication credits.
- Medicare PDP available statewide.
WellCare serves approximately 25,000 Medicare members across the state.

WellCare’s Ohio Medicare Presence:
- Approximately 5,000 Medicare Advantage members.
- Approximately 20,000 Medicare Prescription Drug Plan members.
- All Plans Offer:
  - Preventative dental
  - Vision
  - Medicare PDP available statewide.

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<tr>
<th>County</th>
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<td>Greene</td>
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<tr>
<td>Lake</td>
<td>Medicare PDP plans available</td>
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</tbody>
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WellCare’s Texas Medicare Presence:

- Approximately 20,000 Medicare Advantage members across 12 counties.
- Approximately 8,000 Medicare Prescription Drug Plan members.
  - All Medicare plans offer a Pay-for-Performance program that promotes the timely completion of health care and preventive services, and improves the quality of care for eligible members.
  - Medicare PDP available statewide.
As of June 30, 2013

WellCare’s Louisiana Medicare Presence:

• Approximately 8,000 Medicare Advantage members across 20 parishes
• Approximately 7,000 Medicare Prescription Drug Plan members.
• All Medicare plans offer a Pay-for-Performance program that promotes the timely completion of health care and preventive services, and improves the quality of care for eligible members.
• Medicare PDP available statewide.
Program Overview

- Eligibility for Medicare is solely determined by the Centers for Medicare and Medicaid Services (CMS)

- WellCare’s Medicare Advantage products include HMO, HMO/Point-of-Service (HMO-POS) and Dual Special Needs Plans (DSNP)

- WellCare’s Medicare Advantage plans cover all of the benefits provided by Traditional Medicare plus added benefits, which may include:
  - No or low monthly health plan premiums with predictable co-pays for in-network services
  - Outpatient prescription drug coverage
  - Routine dental, vision and hearing benefits
  - Preventive care from participating providers with no co-pay

*Availability of coverage varies by plan*
Program Overview

- A member’s eligibility status can change at any time

- All providers should consider requesting and copying a member’s identification card, along with additional proof of identification such as a photo ID, and filing them in the patient’s medical record

- Additionally, you must verify patient eligibility, enrollment and benefit coverage prior to service delivery. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients

- Refer to [www.wellcare.com/medicare/our_plans](http://www.wellcare.com/medicare/our_plans) for more information
Benefits of Partnership

When you join WellCare as a participating provider, you gain…

- A Collaborative Relationship – we want to work with you as partners focused on optimizing outcomes for our members
- Local Market Focus – dedicated staff to serve providers in the communities we serve
- Prompt Provider Payment – receiving claims electronically, processing claims rapidly
- Quality Improvement Programs – patient-focused with an emphasis on care and sharing data
- Diverse Network – selection of experienced and qualified providers who offer multilingual capabilities and cultural competencies
WellCare Provider Resources

- Providers have access to a variety of easy-to-use reference materials on our website. The information on our website is the most-up-to-date and should be referenced often, including:
  - Resource Guides related to claims, authorizations, EFT and how to contact us
  - Provider Manuals
  - Clinical Practice and Clinical Coverage Guidelines
  - Provider and Pharmacy lookup
  - Quick Reference Guides that provide contact information for specific departments and authorization information
  - Authorization Lookup Tool for quick searches of CPT codes
  - Provider Education

- By registering for WellCare’s secure, online Provider Portal, providers have access to member eligibility and co-pay information, authorization requests, claims status and inquiries, a provider inbox to receive specific messages from WellCare and provider training.

- Provider Relations representatives are available to assist in resolving many requests. Contact your local market office for assistance.
Provider Relations and Customer Service

Provider Relations Responsibilities

- Questions/concerns about contract status, credentialing status
- Provider Education
- Provider configuration in WellCare’s system
- Providers requesting an application to participate
- Assist providers with registering for secure web portal
- Assist providers with registering for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
- Investigates trends of inappropriate payment

Customer Service Responsibilities

- Verification of member benefits
- Member eligibility verification
- Provider ID information
- Claim Status
- General claims inquiries
- Appeals status and inquiries
- Authorization status and inquiries
- EFT Inquires
- Researches post-payment claims issues and takes necessary action for resolution
- Interacts with all operational areas for resolution of claims issues
- Provider demographics
- Coordination of Benefits

Note: Has the ability to escalate the issue if it cannot be resolved during the call.
Covered Services

Providers must verify member eligibility, enrollment and benefit coverage prior to service delivery. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. For more information on Covered Services, refer to the Provider Manual or the CMS website.

Some of the Covered Services for WellCare members include:

• Behavioral health services such as inpatient, partial hospitalization programs (PHP), therapy and other outpatient services

• Medical Services including, but not limited to, Physicians, PhDs, PsyDs, PAs, ARNPs, FQHCs, Allied Health Providers (LCSWs, LPCs, Therapists)

• Alcohol and Substance Abuse Treatment Services

• Durable Medical Equipment (DME) and Medical Supplies

• Home Health Services

• Prescription medications

• Some limits may apply to Covered Services, as per the restrictions required by CMS
Model of Care

- Medicaid Managed Care
- Transportation
- BH/SA
- Optical
- Dental
- Therapy
- Disease Management
- PCP
- Specialists
- Pharmacy Management
- Case Management
- Home and Community Based Care
- Social Service Programs
- Medicare Advantage
- DSNP
- Part D
Behavioral Health - Integration Strategy

KEY components of Behavioral Health Integration

- **One Plan Structure** - holistic approach to medical and behavioral health care
- **Member-Centric Approach to Care** - develop services and programs that are responsive to health care needs of the members we serve
- **Patient Medical and Behavioral Health Homes** - integration of medical and behavioral care in the community, including special populations
- **Commitment to Community Services** - partnership with providers, advocates and stakeholders
- **Use of Best Practices** - that are proven to promote recovery and resiliency
- **Data Integration** - use of data from all components of care to measure performance and drive clinical decisions
- **Pay for Performance** - move toward quality driven utilization management models and alignment of financial incentives
- **Care Coordination** - improve coordination and communication between medical and behavioral health providers
Behavioral Health Integration Strategy
Medical/Behavioral Integration

Primary focus:

- **Comprehensive** physical and behavioral health screening
- **Engagement of consumers** at multiple levels of care (e.g., program design, self-management, care plan development)
- **Shared development of care plans** addressing physical and behavioral health
- **Clinical Advisory Council** - participation from behavioral and medical clinical leaders in development, implementation and evaluation of health integration strategies
- **Transparency in care management** - sharing data with stakeholders that show outcomes and performance
- **Ongoing training** and education of medical and behavioral health providers
- **Standardized protocols** and evidence-based guidelines that can be tailored to the needs of the members we serve
- **Reduction of avoidable emergency and inpatient utilization** by supporting the development and use of a wide range of community based services
### Behavioral Health Integration Strategy

**Case Management Integrated Program Goals**

#### Four Quadrant Strategy

<table>
<thead>
<tr>
<th>Quadrant II</th>
<th>Quadrant IV</th>
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<tbody>
<tr>
<td>Patients with <em>high behavioral health and low physical health needs.</em></td>
<td>Patients with <em>high behavioral health and high physical health needs.</em></td>
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<tr>
<td>Served in Primary care and specialty mental health.</td>
<td>Served in primary care and specialty mental health settings.</td>
</tr>
<tr>
<td>(Example: Patients with Bipolar and chronic pain)</td>
<td>(Example: patients with Schizophrenia and metabolic syndrome or hepatitis C)</td>
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<tr>
<td>Note: when mental Health needs are stable, often mental health care can be transitioned back to primary care</td>
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<tr>
<td>❖ [Managed by BH CM Tele or Field](Primary Behavioral CM)</td>
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<tr>
<th>Quadrant I</th>
<th>Quadrant III</th>
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<tr>
<td>Patients with <em>low behavioral health and low physical needs.</em></td>
<td>Patients with <em>low behavioral health and high physical needs.</em></td>
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<tr>
<td>Served in primary care setting</td>
<td>Served in Primary Care setting.</td>
</tr>
<tr>
<td>(Example: patients with moderate alcohol abuse and fibromyalgia)</td>
<td>(Example: patients with moderate depression and uncontrolled diabetes)</td>
</tr>
<tr>
<td>❖ <em>No Medical CM or BH CM needed</em></td>
<td>❖ [Managed by Medical CM No BH CM involvement](Primary Medical CM)</td>
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<tr>
<td><em>(Primary Wellness)</em></td>
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Behavioral Health Integration Strategy

Elements of Community Involvement:

Optimal Outcomes for Consumers / Members & their Families

- Best Practices
  - Communications
  - Information
  - Education & Training
  - Project Management

- BH Market ADVISORY COUNCILS

- Formulate Policy
- Revise
- Implement
- Measure Performance
  - Data
  - Information
Data can be analyzed by hospital, provider, consumer / member, level of care, etc. for the earliest possible identification of outlier results. Outliers are targeted for additional services, such as intensive case management or provider consultation.
Behavioral Health Services

• Members do not need a referral for behavioral health services. WellCare requires a prior authorization for some outpatient services. Some services require a simple case registration, but will require concurrent review at set points in time to facilitate good clinical outcomes.

• PCPs may provide any clinically appropriate behavioral health services within the scope of their practice.

• WellCare strongly encourages open communication and collaboration between PCPs and behavioral health providers, including, but not limited to:
  
  o Behavioral health providers are required to submit, with the member’s or member’s legal guardian’s consent, an initial and quarterly summary report of the member’s behavioral health status to the PCP.

  o Behavioral health providers should communicate with the member’s PCP upon discharge from inpatient hospitalization.

  o If a member’s medical or behavioral condition changes, WellCare expects both the PCP and behavioral health provider to communicate those changes with each other, especially any changes in medications that need to be discussed and/or coordinated.

• For more information on WellCare’s Behavioral Health program, refer to the Provider Manual and the Quick Reference Guide.
Provider Responsibilities

• All participating providers are responsible for adhering to the Participation Agreement and the Provider Manual and all applicable CMS requirements.

• The WellCare Provider Manual supplements the Agreement and provides information on requirements such as:
  o Provider Billing and Address changes
  o Access and availability standards, including after-hours coverage
  o Credentialing and Re-credentialing requirements
  o Assisting members with special health care needs, including behavioral, developmental and physical disabilities and/or environmental risk factors
  o Claims and Encounter data submission requirements
  o Specific medical records requirements, record retention timeframes and Advance Directive and Living Wills documentation
  o Mandatory participation in Quality Improvement projects and medical record review activities such as HEDIS®
  o Adhering to WellCare’s compliance requirements, including provider training and safeguarding member confidentiality in compliance with HIPAA

• For more information on Provider rights and responsibilities, refer to the Provider Manual.
Member Rights

- Member rights are outlined in the Member Handbook, which is mailed to all newly enrolled members.

- Member rights include, but are not limited to:
  - Being treated with fairness, respect and dignity
  - Having the availability of language designated materials, include interpreter and sign language services for deaf or hard-of-hearing members
  - Being able to make complaints about WellCare or the care provided
  - Appealing medical or administrative decisions WellCare has made by using the Appeals and Grievances system
  - The protection of their privacy
  - Having a say in WellCare's member rights and responsibilities policy
  - Having all these rights apply to the person who can legally make health care decisions for the member
  - Using these rights no matter what their sex, age, race, ethnic, economic, educational or religious background.

- For more information on member rights, refer to the Member Handbook or the Provider Manual.
Member Responsibilities

• Members are responsible for:
  o Knowing how WellCare works by reading the Member Handbook
  o Carrying their WellCare card with them at all times and presenting their card prior to receiving services
  o Being on time for appointments
  o Supply information (to the extent possible) that WellCare and its providers need in order to provide care;
  o Canceling and rescheduling an appointment prior to missing their scheduled appointment
  o Respecting providers, staff and other patients
  o Asking questions if they do not understand medical advice provided
  o Helping to set treatment goals that they agree to with their provider
  o Ensuring that their provider has previous medical records, or access to them

• For more information on member responsibilities, refer to the Member Handbook.
Quality Improvement Program

WellCare’s Quality Improvement (QI) Program activities include, but are not limited to:

- Monitoring clinical indicators and outcomes
- Monitoring appropriateness of care
- Quality studies
- Healthcare Effectiveness Data and Information Set (HEDIS®) measures
- Medical records audits
- Member and provider satisfaction
- Preventative health

Providers are contractually required to participate in QI projects and medical record review activities.

HEDIS® is a mandatory process that occurs annually. It is an opportunity for WellCare and its providers to demonstrate the quality and consistency of care that is available to members.

For more information on WellCare’s Quality Improvement Program, refer to the Provider Manual.
Quality Improvement Program

- Mental Health and Substance Abuse HEDIS® Measures

  ✓ **Antidepressant Medication Management** - Acute phase: 84 days of continuous therapy. Continuation phase: 180 days of continuous therapy

  ✓ **Patients discharged from an inpatient mental health admission receive**: One follow-up encounter with a mental health provider within 7 and 30 days after discharge

  ✓ **Initiation and engagement of alcohol and other drug dependence treatment** - Patients diagnosed with alcohol and/or other drug dependence who initiate treatment within 14 days of diagnosis and who receive two additional services within 30 days of the initiation visit

Non-HEDIS® Measures

  ✓ **Members with Severe Mental Illness (SMI)** – Members who are followed up with a psychiatrist annually (within the measurement year)

  ✓ **30-Day Readmissions** – Monitor for Members who have been readmitted to an inpatient level of care.
Medicare Stars Rating System

- The CMS rating system that Evaluates the relative quality of private plans offered to Medicare beneficiaries through the Medicare Advantage program.
- Plans are measured on a 1 – 5 star scale.
- Star ratings exist for both Part C and Part D focusing on a variety of quality and service metrics.
- Star scores are published on the CMS website for members to evaluate health plans during the Annual Enrollment Period (AEP).
- Plans with a five-star rating receive a “High Performing Icon” on the website and plans with less than a three-star rating for the past three years receive a “Low Performing Icon” on the website.
- Plans are also eligible for a bonus in premium from CMS if they have a four-star or higher rating.
Medicare Stars Rating System

- Components of the Stars-score include:
  - **HEDIS®**
    - Measures clinical performance indicators such as access to care, receipt of preventive services, and management of chronic conditions
  - **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**
    - Evaluates member satisfaction with providers, health plan, and overall experience
  - **Medicare Health Outcomes Survey (HOS)**
    - Evaluates physical and mental health and quality of life of Medicare beneficiaries
  - **Administrative Measures**
    - Evaluates measures such as complaints, customer service, appeals, disenrollment, and audit performance
  - **Part D (Pharmacy) Measures**
Utilization Management (UM)

General Information

• WellCare’s Utilization Management (UM) program includes review processes such as notifications, referrals, prior authorization, concurrent review, retrospective review, initial UM determinations and reconsiderations as needed.

• WellCare utilizes InterQual™ criteria and LOCUS and CALOCUS for behavioral health and American Society for Addiction Medicine (ASAM) for substance abuse.

• WellCare supports Recovery and Resiliency as guiding principles for all care delivered.
  o Behavioral Health Authorization Tools can be found on our website under Provider Resources
  o Decision timeframes are determined by NCQA requirements, contractual requirements or a combination of both. See the Provider Manual for decision timeframes
  o Prior authorizations and case registrations may be requested via fax, phone or online via the secure Provider Portal
  o For more information on prior authorizations, and the information necessary to include in your request, refer to the Provider Manual and the Quick Reference Guide
Utilization Management (UM) (cont.)

• Concurrent Review

  o WellCare conducts concurrent review of services to promote good clinical outcomes. Concurrent reviews may be done via fax submission of updated clinical data or telephonically.

  o WellCare care managers are trained to facilitate integrated and individualized care to move the member through the episode of care as effectively as possible, avoid readmissions to higher levels of care, and meet the members goals for treatment.

  o Discharge Planning should begin upon admission and identify the member’s post-hospital needs
    ▪ The attending physician, hospital discharge planner, PCP, ancillary providers, behavioral health providers and/or community resources are required to coordinate care and post-discharge services to ensure the member receives the appropriate level of care
    ▪ Hospitals should provider a member’s PCP and outpatient treating provider a discharge summary to ensure continuity of care
    ▪ Hospitals should coordinate transfers to other levels of care such as a psychiatric residential treatment facility (PRTF), Partial Hospitalization Program and Intensive Outpatient Program

  o Short Term Case Management identifies members in the hospital and/or recently discharged who are at risk for hospital readmission
    ▪ The member is contacted by a WellCare Care Manager to assist the member in reducing avoidable readmissions and/or offer Case or Disease Management
• **Retrospective Review**
  
  o WellCare reviews post-service requests for authorizations of inpatient admissions or outpatient services
  
  o This review includes making coverage determinations for the appropriate level of services, quality issues, utilization issues and the rationale behind failure to follow WellCare’s prior authorization guidelines
  
  o A retrospective review can be initiated by WellCare or the provider

• **Transition of Care (Effective 12/1/13)**
  
  o During the first 30 days of enrollment, authorization is not required for certain members with previously approved services
  
  o Members will have specific authorizations entered for the associated provider to avoid any member or provider abrasion for Transition of Care (TOC) for up to 90 days
    
    ▪ WellCare will continue to be responsible for the costs of continuation of such medically necessary Covered Services for in- or out-of-network until WellCare can reasonably transfer the member to a service and/or network provider without impeding service delivery
    
    ▪ Providers must properly document these services and determine any necessary follow up
  
  o When a WellCare member is to be dis-enrolled from WellCare and transitioned to another managed care plan, WellCare will provide a TOC report to the receiving plan
Utilization Management (UM) (cont.)

• The following forms are required for providers to request services identified as needing a Prior Authorization (PA) from WellCare:
  o **Initial Outpatient Service Request Form** (A guidance document is also available to assist providers)
  o **BH Service Request Form**—Intensive Outpatient and Standard Outpatient Requests
  o **BH Request Form**—Psychological and Neuropsychological Testing Requests
  o **BH Service Request Form**—Inpatient and Partial Hospitalization Program Requests
  o **BH Service Request Form**—Electroconvulsive Therapy Requests

• These forms are made available to assist you in gathering all pertinent information to enable WellCare to provide a timely response to your request. Forms are located on the website on the Provider Resources page under Forms and Documents.
Utilization Management (UM) (cont.)

- Refer to the Provider Manual for additional information including, but not limited to:
  - Definition of Medical Necessity
  - Criteria for UM decisions
  - Decision timeframes for service authorizations
  - Non-covered services and procedures
  - Reconsideration for adverse determination (i.e., appeal)
  - Proposed Actions
  - Individuals with Special Health Care Needs (ISHCN)
  - Second Medical Opinion
  - Forms for authorizations, Coordination of Care and more

- Forms are made available to assist you in gathering all pertinent information to enable WellCare to provide a timely response to your request. Forms are located on the website on the Provider Resources page under Forms and Documents.

- For more information on UM and Case/Disease Management, refer to the Provider Manual. For more information on authorizations and/or how to contact UM, refer to your Quick Reference Guide
Case Management and Disease Management

• WellCare offers comprehensive integrated Case Management services to facilitate patient assessment, planning, and advocacy to improve health outcomes for patients.

• Key elements of the Case Management program include:
  o Clinical Assessment and Evaluation
  o Care Planning
  o Service Facilitation and Coordination
  o Member Advocacy
  o Work with existing case managers in CMHCs, Health Homes and other organizations

• Disease Management is a population-based strategy that involves consistent care for members with certain disease states.

• The program includes member education, monitoring of the member, and consistent use of Clinical Practice Guidelines.

• To refer to either the Case Management or Disease Management programs, contact the Case Management Referral line. Members may self-refer by calling the Care Management link or contacting the Nurse Advice Line. The phone number to the Case Management Referral Line is located on the Quick Reference Guide.
Claims Submission Requirements

• Claims, paper and electronic, must be submitted using HIPAA compliant 837 format.

• Always include the WellCare electronic Payor ID

• All claims should include all necessary, completed, correct and compliant data including:
  o Current CPT and ICD-9 (or its successor) codes with appropriate modifiers
  o Tax ID
  o NPI number(s) - with the exception of atypical providers. Atypical providers must pre-register with WellCare before submitting claims to void NPI rejections
  o Provider and/or practice name(s) that match those on the W-9 initially submitted to WellCare
  o Valid taxonomy code
  o An authorization number, if applicable

• WellCare encourages providers to submit electronically via Electronic Data Interchange (EDI) or Direct Data Entry (DDE). Both are less costly than paper and, in most instances, allow for quicker claims processing.

• All claims and encounter transactions are validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines

• For more information on Claims submission requirements and timeframes, refer to the Provider Manual or the Provider Resource Guide. For assistance with EDI or DDE, you can contact us at EDI-Master@WellCare.com
Sample Claim Forms—CMS 1500 and the UB 04

Submission Sample

Please refer to NUCIC (National Uniform Claim Committee) for complete detailed information about paper claim submission and refer to the 837 Professional Implementation Guide by Washington Publishing Company (May 2004) for any EHR-related issues.

UB 04 Claim Submission Sample

Please refer to NUCIC (National Uniform Billing Committee—UB-04 forms) for complete detailed information about paper claim submission and refer to the 837 Institutional Implementation Guide by Washington Publishing Company (May 2004) for any EHR-related issues.
Appeals and Grievances

Complaints and Administrative Reviews

- Providers have the right to file a complaint regarding provider payment or contractual issues, but it must be filed within 30 calendar days or it will be denied for untimely filing.

- Providers may act on behalf of the member with the member’s written consent.

- WellCare will review the appeal for medical necessity and conformity to WellCare guidelines. Cases lacking necessary documentation will be denied.

- When submitting a complaint:
  - Supply specific, pertinent documentation that supports the complaint.
  - Include all medical records that apply to the service.
  - Submit the appeal and accompanying documentation to the address on the Quick Reference Guide.

- Upon review of the appeal, WellCare will either reverse or affirm the original decision and notify the provider.

- Members have the right to request an Administrative Law Hearing after pursuing resolution via WellCare. Under certain circumstances, benefits continue while the appeal and Hearing are pending.
Appeals and Grievances (cont.)

Grievances

• Providers have the right to file a written complaint for issues that are non-claims related within established timeframes

• WellCare will provide written resolution to the provider within established timeframes. Extensions may be requested by WellCare and/or the provider

• Providers may act on behalf of the member with the member’s written consent
  - The member may request an Administrative Law Hearing if WellCare does not meet the 90 day resolution timeframe

• For more information on provider complaints and grievances, including submission and determination timeframes, and how to submit, refer to the Provider Manual and the Quick Reference Guide
WellCare’s Compliance Program

• All providers, including provider employees and sub-contractors, their employees and delegated entities, are required to comply with WellCare’s compliance program requirements.

• WellCare’s compliance requirements include, but are not limited to, the following:
  o Provider Training Requirements
  o Limitations on Provider Marketing
  o Code of Conduct and Business Ethics
  o Cultural Competency and Sensitivity
  o Fraud, Waste and Abuse (FWA)
  o Americans with Disabilities Act (ADA)
  o Medical Records Retention and Documentation including OB/GYN requirements

• For more information on WellCare’s Compliance program and specific compliance requirements, refer to the Provider Manual.
Pharmacy Services

• To ensure members receive the most out of their pharmacy benefit, please consider the following guidelines when prescribing:
  o Follow national standards of care guidelines for treating conditions
  o Prescribe drugs on WellCare’s Preferred Drug List (PDL)
  o Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class
  o Evaluate medication profiles for appropriateness and duplication of therapy

• WellCare has pharmaceutical utilization management (UM) tools that are used to optimize the Pharmacy program. These UM tools are described in further detail in the Provider Manual including:
  o Preferred Drug List (PDL)
  o Coverage Determination process
  o Mandatory Generic Policy
  o Step Therapy (ST)
  o Quantity Level Limit (QL)
  o Pharmacy Lock-In Program
Dual-Eligible Members

- WellCare provides coverage for dual-eligible members
  - Those individuals who are entitled to Medicare Part A and/or B and are eligible for some form of Medicaid benefit, through our HMO, POS and DSNP products
- A Dual Special Needs Plan, or DSNP, is a special type of plan that provides more focused health care for people who have both Medicare and Medicaid
- Types of dual-eligible members vary based on their Medicare Savings Program (MSP) category
- “Zero-cost share” dual-eligible members pay no Part A or B cost-share
- You are prohibited from balance-billing “zero-cost share” members for either the balance of the Medicare rate or the provider’s customary charges for Part A or B services
Dual-Eligible Members

- When referring the member to another provider, make every attempt to refer to a provider who participates with both WellCare and the state Medicaid agency.

- In the event the member loses or has a change in Medicaid status, WellCare will allow for a 3-month Deeming Period for all members in a DSNP plan:
  - The Deeming Period allows the member to attempt to regain their Medicaid eligibility and/or status.
  - During the Deeming Period, WellCare will pay *100% of the Medicare allowable to protect members from cost-sharing.
  - Remember: You may not balance bill the member.

* With the exception of the Florida Select plan. These members may be responsible for cost-share.
Dual-Eligible Members - DSNP

- Health plans are required to provide their Special Need Plans (SNP) Provider Network with information on their basic model of care, this includes WellCare’s DSNP plans.
- WellCare’s Model of Care (MOC) is tailored specifically to dual-eligible members in an effort to meet the populations’ functional, psychosocial, and medical needs in a member-centric fashion.

Provider participation is required and entails the following:
- Completing the required MOC training via a printable self-study packet or online module.
- Reviewing and updating the member care plan faxed to you by the Case Management Department.
- Participating in Interdisciplinary Care Team (ICT) activities for all DSNP members, and providing feedback as appropriate.
For more on dual-eligible members, refer to the Provider Manual for such items as:

- Types of dual-eligible members
- Payment and Billing
- Dual-eligible State-Specific Contract Obligations
- In-depth MOC information
Pharmacy Services (cont.)

Additional important information covered in the Provider Manual includes:

- Non-covered drugs and/or drug categories that are excluded from the Medicaid benefit
- Over-the-Counter (OTC) medications available to the member with a prescription
- Requesting additions and exceptions to the PDL through the Coverage Determination process, including information on:
  - How to submit a coverage determination request
  - When a coverage determination is required, including, but not limited to:
    - Most self-injectable and infusion medications
    - Drugs not listed on the PDL
    - Drugs listed on the PDL but still require a Prior Authorization
    - Brand name drugs when a generic exists
- Requesting an appeal of a coverage determination request decision
- For more information on WellCare’s Pharmacy program, refer to the Provider Manual, the Quick Reference Guide and the web for appropriate Forms, Documents and contact information.
For More Information…

• Review the **Provider Manual** for more detailed information about provider requirements and how-to’s including:

<table>
<thead>
<tr>
<th>Provider and Member Administrative Guidelines</th>
<th>Requirements for Facilities and Inpatient Providers</th>
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</thead>
<tbody>
<tr>
<td>Delegated Entities</td>
<td>Claims</td>
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<tr>
<td>Credentialing</td>
<td>Appeals and Grievances</td>
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<td>Pharmacy Services</td>
<td>Compliance</td>
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<td>Quality Improvement</td>
<td>Medical Records Requirements</td>
</tr>
<tr>
<td>Cultural Competency</td>
<td>Behavioral Health Services</td>
</tr>
</tbody>
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• Refer to the **Provider Resource Guide** and **Provider How-To Guide** as your guides to the most common transactions with WellCare, including:
  • Registering for, and how to use WellCare’s provider portal such as member eligibility and co-pay information, authorization requests, claims status and inquiry, provider news and more;
  • How to file a claim via paper, electronically or via WellCare’s Direct Data Entry (DDE);
  • How to file a grievance or appeal

• Refer to the **Quick Reference Guide** for authorization requirements, addresses and phone numbers for key departments.

• Refer to the **Clinical Practice Guidelines** and **Clinical Coverage Guidelines** to determine medical necessity, criteria for coverage of a procedure or technology, and best practice recommendations based on available clinical outcomes and scientific evidence.
WellCare Contact Information:

How you contact WellCare by PHONE to request Behavioral Health services does not change:

The Provider Services telephone number can be found on the Quick Reference Guide or WellCare Website for each state.

- Eligibility Verification, Claims, Utilization Management, Language Line, and Provider Complaints, Member inquiries

**FAX** requests for IP and OP Behavioral Health services:

<table>
<thead>
<tr>
<th>State</th>
<th>Outpatient Requests</th>
<th>Inpatient Requests</th>
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</thead>
<tbody>
<tr>
<td>New Jersey</td>
<td>(855) 671-0256</td>
<td>(855) 671-0257</td>
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<tr>
<td>Illinois</td>
<td>(855) 713-0593</td>
<td>(855) 713-0592</td>
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<td>New York</td>
<td>(855) 713-0589</td>
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