Table of Contents

Table of Contents............................................................................................................1
2017 Medicare Advantage Provider Manual Revision Table...........................................5
   Added Required Notification to Members for Observation Services ..........................5
Section 1: Welcome to WellCare.......................................................................................7
   Mission and Vision ....................................................................................................7
   Purpose of this Manual .............................................................................................7
   WellCare Medicare Advantage ..............................................................................8
   WellCare Products ....................................................................................................8
   Provider Services ......................................................................................................9
   Website Resources ...................................................................................................10
Section 2: Provider and Member Administrative Guidelines ........................................12
   Provider Administrative Overview .........................................................................12
   Responsibilities of All Providers ............................................................................13
   Access Standards .....................................................................................................16
   Responsibilities of Primary Care Providers ............................................................17
   Assignment of Primary Care Provider ....................................................................18
   Termination of a Member .........................................................................................18
   Domestic Violence and Substance Abuse Screening ..............................................18
   Smoking Cessation ....................................................................................................18
   Adult Health Screening ............................................................................................19
   Cultural Competency Program and Plan .................................................................19
   Cultural Competency Survey ...................................................................................20
   Member Administrative Guidelines .........................................................................20
   Overview ..................................................................................................................20
   Evidence of Coverage Booklet ................................................................................20
   Enrollment ................................................................................................................21
   Member Identification Cards ....................................................................................21
   Eligibility Verification ...............................................................................................21
   Member Rights and Responsibilities ........................................................................21
   Changing Primary Care Providers .........................................................................22
   Women’s Health Specialists .....................................................................................22
   Hearing-Impaired, Interpreter and Sign Language Services .....................................22
Section 3: Quality Improvement ......................................................................................24
   Overview ..................................................................................................................24
   Program Methodology ..............................................................................................25
   Quality Improvement Activities ...............................................................................29
   Key Program Components .......................................................................................33
   Access/Availability Monitoring ...............................................................................33
   Clinical Practice Guideline Development and Review ............................................33
   Concerns/Complaints/Grievances ...........................................................................33
   Continuity and Coordination of Care ......................................................................33
   Credentialing ..............................................................................................................34
   Medical Record Review ............................................................................................34
   Member Satisfaction ................................................................................................35
   Operational Service Performance ............................................................................35
   Peer Review ...............................................................................................................35
   Pharmacy Program ...................................................................................................36
   Medical Records .......................................................................................................41
   Web Resources ..........................................................................................................43
Section 4: Utilization Management, Care Management and Disease Management.........44

WellCare Health Plans
Medicare Advantage Provider Manual
Effective: February 24, 2017
Provider Services (toll free): 1-855-538-0454
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Utilization Management</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Medical Necessity</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization for Members Enrolled in a Point of Service Plan</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Notification</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Concurrent Review</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Discharge Planning</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Retrospective Review</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Referrals</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Criteria for Utilization Management Determinations</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Organization Determinations</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Reconsideration Requests</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Emergency Services</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Transition of Care</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Continued Care with a Terminated Provider</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Continuity of Care</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Second Opinion</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Medicare Quality Improvement Organization Review Process</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Required Notification to Members for Observation Services</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Notification of Hospital Discharge Appeal Rights</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Availability of Utilization Management Staff</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Care Management Program</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Provider Access to Care Management</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Disease Management Program</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Candidates for Disease Management</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Access to Care and Disease Management Programs</td>
<td>57</td>
</tr>
<tr>
<td>Section 5: Claims</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Updated Electronic Funds Transfer (EFT) and Electronic Remittance</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Advised (ERA) Process</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Timely Claims Submission</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Claims Submission Requirements</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Claims Processing</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Encounters Data</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Balance Billing</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Member Expenses and Maximum Out-of-Pocket</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Provider-Preventable Conditions</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Reopening and Revising Determinations</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Disputed Claims</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Corrected or Voided Claims</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Reimbursement</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Medicare Overpayment Recovery</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Benefits During Disaster and Catastrophic Events</td>
<td>71</td>
</tr>
<tr>
<td>Section 6: Credentialing</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>Practitioner Rights</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Baseline Criteria</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Liability Insurance</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Site Inspection Evaluation</td>
<td>74</td>
</tr>
</tbody>
</table>

WellCare Health Plans
Medicare Advantage Provider Manual
Effective: February 24, 2017
Provider Services (toll free): 1-855-538-0454
Page 2 of 110
Covering Physicians ................................................................. 75
Allied Health Professionals .................................................... 75
Ancillary Health Care Delivery Organizations ............................ 75
Re-Credentialing .................................................................... 75
Updated Documentation .......................................................... 75
Office of Inspector General Medicare/Medicaid Sanctions Report. 76
Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials ............................................. 76
Participating Provider Appeal through the Dispute Resolution Peer Review Process ......................................................... 76
Delegated Entities ................................................................ 78

Section 7: Reconsiderations (Appeals) and Grievances .............................. 79
Appeals .................................................................................. 79
Provider Retrospective Appeals Overview .................................. 79
Provider Retrospective Appeals Decisions ............................... 79
Member Reconsideration Process ............................................. 80
Standard Pre-Service and Retrospective Reconsiderations .......... 81
Expeditied Reconsiderations ..................................................... 82
Member Reconsideration Decisions ......................................... 82
Grievances ........................................................................... 83
Provider Grievance .................................................................. 83
Member Grievance Overview .................................................. 83
Grievance Resolution .............................................................. 84

Section 8: Compliance ................................................................ 86
Compliance Program - Overview ............................................. 86
Marketing Medicare Advantage Plans ...................................... 86
Code of Conduct and Business Ethics ................................. 87
Overview ................................................................................. 87
Fraud, Waste and Abuse ............................................................ 87
Confidentiality of Member Information and Release of Records 88
Disclosure of Information ......................................................... 89

Section 9: Delegated Entities ........................................................ 90
Overview ................................................................................ 90
Compliance ............................................................................ 90

Section 10: Dual-Eligible Members .................................................... 91
Overview ................................................................................ 91
Types of Dual-Eligible Members ............................................. 91
Payments and Billing ............................................................... 91
Referral of Dual-Eligible Members ........................................... 93
Dual-Eligible Members Who Lose Medicaid Eligibility/Status .... 93
Dual-Eligible State-Specific Contract Obligations ..................... 94
Florida ................................................................................. 94
New Jersey ................................................................. 94
New York ............................................................................. 95
Texas .................................................................................. 95
Tennessee ............................................................................. 95
Louisiana .............................................................................. 95
Georgia ............................................................................... 96
DSNP Care Management Program ......................................... 96
Overview ................................................................................. 96
Provider Required Participation ............................................ 97

Section 11: Behavioral Health ........................................................ 98
Overview ................................................................................ 98
## Table of Contents

- Behavioral Health Program ....................................................................................................... 98
- Coordination of Care Between Medical and Behavioral Health Providers ................................ 98
- Responsibilities of Behavioral Health Providers ......................................................................... 99

### Section 12: Pharmacy ................................................................................................................. 100
- Formulary .................................................................................................................................... 100
- Additions and Exceptions to the Formulary .................................................................................. 101
- Coverage Limitations .................................................................................................................. 101
- Generic Medications .................................................................................................................... 101
- Step Therapy ............................................................................................................................... 101
- Prior Authorization ....................................................................................................................... 101
- Quantity Limits ........................................................................................................................... 102
- Therapeutic Interchange ............................................................................................................... 102
- Mail Service ............................................................................................................................... 102
- Injectable and Infusion Services ................................................................................................. 102
- Over-the-Counter Medications .................................................................................................... 102
- Member Co-Payments ................................................................................................................ 102
- Coverage Determination Request Process ................................................................................ 102
- Obtaining a Coverage Determination Request ......................................................................... 103
- Medication Appeals .................................................................................................................... 103

### Section 13: Definitions and Abbreviations .................................................................................. 104
- Definitions .................................................................................................................................. 104
- Abbreviations .............................................................................................................................. 107

### Section 14: WellCare Resources ................................................................................................. 110
## 2017 Medicare Advantage Provider Manual Revision Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Section</th>
<th>Comments</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/3/16</td>
<td>Section 1: Welcome to WellCare</td>
<td>Updated language under Purpose of This Manual section</td>
<td>7</td>
</tr>
<tr>
<td>4/29/16</td>
<td>Section 1: Welcome to WellCare</td>
<td>Updated language on plan-directed care</td>
<td>9</td>
</tr>
<tr>
<td>4/29/16</td>
<td>Section 1: Welcome to WellCare</td>
<td>Added information on updated IVR system</td>
<td>9</td>
</tr>
<tr>
<td>1/12/16</td>
<td>Section 2: Provider and Member Administrative Guidelines</td>
<td>Updated the following sections: Maximum Out-of Pocket, Deductible, Responsibilities of Primary Care Providers, Cover Physicians/Providers, Termination of a Member, Domestic Violence and Substance Abuse Screening</td>
<td>13</td>
</tr>
<tr>
<td>9/18/15</td>
<td>Section 3: Quality Improvement</td>
<td>Added information on Market withdrawals</td>
<td>37</td>
</tr>
<tr>
<td>4/12/16</td>
<td>Section 4: UM/CM/DM</td>
<td>Updated Transition of Care section</td>
<td>51</td>
</tr>
<tr>
<td>12/22/2016</td>
<td>Section 4: UM/CM/DM</td>
<td>Added Required Notification to Members for Observation Services</td>
<td>54</td>
</tr>
<tr>
<td>1/13/16</td>
<td>Section 5: Claims</td>
<td>Added EFT/ERA information</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added Pre-Admission Service Payment Policy information</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Updated Balance Billing information</td>
<td>65</td>
</tr>
<tr>
<td>10/27/16</td>
<td></td>
<td>Updated Disputed Claims timeframe</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Updated Corrected or Voided Claims section</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Updated Overpayment Recovery section</td>
<td>69</td>
</tr>
<tr>
<td>1/13/16</td>
<td>Section 8: Compliance</td>
<td>Added ICD-10 information</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Updated Fraud, Waste and Abuse section</td>
<td>86</td>
</tr>
<tr>
<td>2/24/17</td>
<td></td>
<td>Updated Marketing Medicare Advantage Plan</td>
<td>86</td>
</tr>
<tr>
<td>Date</td>
<td>Section</td>
<td>Comments</td>
<td>Page</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
<td>------------------------------------------------------------</td>
<td>------</td>
</tr>
</tbody>
</table>
| 1/13/16  | Section 10: Dual Eligible Members | Updated Dual-Eligible State-Specific Contract Obligations chart  
Added New Jersey DSNP program | 93   |
| 7/11/16  | Section 11: Behavioral Health | Updated Behavioral Health Program section | 97   |
| 10/14/15 | Section 12: Pharmacy     | Updated Obtaining a Coverage Determination Request section | 102  |
| 9/18/15  | All sections             | Updated urls                                              | Throughout manual |
| 4/29/16  | All sections             | Updated urls                                              | Throughout manual |
Section 1: Welcome to WellCare

WellCare Health Plans, Inc. (WellCare) provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicare, Medicaid and Children’s Health Insurance Programs, including prescription drug plans and health plans for families, and the aged, blind and disabled. WellCare’s corporate office is located in Tampa, Florida. WellCare serves approximately 3.7 million Members. WellCare’s experience and exclusive commitment to these programs enable the company to serve its Member and Providers as well as manage its operations effectively and efficiently.

Mission and Vision
WellCare’s vision is to be a leader in government-sponsored health care programs in partnership with the Members, Providers, governments, and communities it serves. WellCare will:

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

WellCare’s core values include:

- Partnership - Members are the reason WellCare is in business; Providers are partners in serving Members; and regulators are the stewards of the public’s resources and trust. WellCare will deliver excellent service to its partners.
- Integrity - WellCare’s actions must consistently demonstrate a high level of integrity that earns the trust of those it serves.
- Accountability - All associates must be responsible for the commitments WellCare makes and the results it delivers.
- Teamwork - With fellow associates, WellCare can expect - and is expected to demonstrate - a collaborative approach in the way it works.

Purpose of this Manual
This Manual is intended for Providers who have contracted with WellCare to deliver quality health care services to Members enrolled in a Medicare Advantage (MA) Benefit Plan.

This Manual serves as a guide to Providers and their staff to comply the policies and procedures governing the administration of WellCare’s Medicare Advantage Government Program and is an extension of and supplements the Provider participation contract entered into with WellCare (Agreement). This Provider Manual replaces and supersedes any previous versions dated prior to February 24, 2017 is available on WellCare’s website. From the wellcare.com home page, select your state from the drop-down menu and click on “Overview” in the “Providers” drop-down menu. A paper copy is available at no charge to Providers upon request.

In accordance with the Agreement, Participating Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to WellCare’s policies and procedures. As policies and procedures change, updates will be issued by WellCare in the form of Provider Bulletins and will be incorporated into subsequent versions of the handbook. Unless otherwise provided in the Agreement, WellCare will communicate changes to the Manual through a Table of Revisions in the front of the Manual, Provider Bulletin posted to the Provider Portal on WellCare’s website, and in the quarterly provider newsletter. For material changes, WellCare will send a formal notice in accordance with the terms of the Agreement.
Unless otherwise provided in the Agreement, WellCare will notify Providers of changes to this Manual through the Medicare Advantage Provider Manual Revision Table in the front of this Manual and through Provider Bulletins that shall be provided by mail, facsimile, or other electronic means. For material changes, WellCare will send formal notice in accordance with the terms of the Agreement. WellCare may release Provider Bulletins that are state-specific and may override the policies and procedures in this Manual for that specific state only.

**WellCare Medicare Advantage**
As a Medicare Advantage managed care organization, coverage includes all of the benefits traditionally covered by Medicare plus added benefits identified in the benefit plans coverage documents. Such additional benefits 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-payment

*Subject to change. Availability varies by plan and county/parish.

**WellCare Products**
WellCare’s products are designed to offer enhanced benefits to its Members as well as cost-sharing alternatives. WellCare’s products are offered in selected markets to allow flexibility and offer a distinct set of benefits to fit Member needs in each area. For more information on WellCare’s products, visit [www.wellcare.com](http://www.wellcare.com).

Below is a list of WellCare’s MA products that may change from time to time as WellCare obtains a license to issue benefits plans under a government contract.

**Health Maintenance Organization (HMO) –** Traditional MA plan. All services must be provided within the WellCare network unless an emergency or urgent need for care arises, or such service is not available in-network. Some services require prior authorization by WellCare, or its designee.

**HMO with Point Of Service Option (HMO-POS) –** The point-of-service (POS) benefit allows Members to access most Medicare covered, Medically-Necessary services from non-network Providers, and they are entitled to use their POS option anywhere in the United States. However, they will pay more to access services outside the network* via their POS benefit, and no guarantee can be made that non-network Providers will accept WellCare insurance for non-emergency services. Please see the below table for specific Covered Service restrictions by state.

<table>
<thead>
<tr>
<th>State</th>
<th>Services NOT covered by POS benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky and Hawaii</td>
<td>Inpatient hospital psychiatric, partial hospitalization, primary care physician (PCP), outpatient behavioral health specialty, psychiatric, outpatient substance abuse, durable medical equipment, end stage renal disease**, Medicare covered zero cost-share preventive, comprehensive dental, vision, hearing, and non-Medicare Covered Services</td>
</tr>
</tbody>
</table>
Plan-directed care is care a Member reasonably believes that he or she was instructed to obtain by a health plan representative such as a contracted physician. Except for items or services which are clearly never covered, or in cases when a Member is individually notified in-writing of an adverse coverage decision in advance, CMS requires plans to pay for all plan directed care, and beneficiaries may never be made liable for more than their in-network cost sharing. Consequently, contracted Providers are required to obtain authorization from WellCare prior to referring Members out-of-network to non-contracted Providers. If a contracted Provider refers a Member to a non-contracted Provider without obtaining prior authorization, WellCare may hold the referring Provider liable for the cost of the Member’s out-of-network care.

**Dual-Eligible Special Needs Plans (DSNP)** – A special type of plan that provides more focused health care for people who have Medicare and are also entitled to assistance from Medicaid. Like all Medicare Advantage plans, it is approved by Medicare. Additionally, it has a contract with the state Medicaid program to coordinate Medicaid benefits. All services** must be provided within the network unless an emergency or urgent need for care arises or such service is not available in-network. Some services require prior authorization by WellCare or its designee.

*All Members who receive renal dialysis services while temporarily outside of their service area will pay the in-network cost share, regardless of the Provider’s network affiliation.*

**Provider Services**

**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 key-pad

**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 wellcare.com under the Providers section of each State-specific page, “Overview.”

Providers may contact the appropriate departments at WellCare by referring to the state-specific Quick Reference Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

In addition, WellCare Provider Relations representatives are available to assist Providers. Please contact the local market office for assistance.

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

Available resources include:
- Provider Manuals
- Quick Reference Guides
- Clinical Practice Guidelines
- Clinical Coverage Guidelines
- WellCare Companion Guide
- Forms and documents
- Pharmacy and Provider lookup (directories)
- Authorization look-up tool
- Training materials and job aids
- Newsletters
- Member rights and responsibilities
- Privacy statement and notice of privacy practices

Secure Provider Portal – Benefits of Registering
WellCare’s secure online Provider Portal offers immediate access to an assortment of useful tools.

Providers can create unlimited individual sub-accounts for staff members, allowing for separate billing and medical accounts.

All Providers who create a login and password using their Provider Identification (Provider ID) number have access to the following features:
- Claims submission status and inquiry: Submit a new claim, check the status of an existing claim, and customize and download reports.
- **Member eligibility and co-payment information**: Verify Member eligibility and obtain specific co-payment information.
- **Authorization requests**: Submit authorization requests, attach clinical documentation and check authorization status. Providers can also print and/or save copies of authorization forms.
- **Pharmacy services and utilization**: View and download a copy of the Formulary, see, access pharmacy utilization reports and obtain information about WellCare's pharmacy services.
- **Training**: Take required training courses and complete attestations online.
- **Reports**: Access reports such as active Members, authorization status, claims status, eligibility status, pharmacy utilization, and more.
- **Provider news**: View the latest important announcements and updates.
- **Personal inbox**: Receive notices and key reports regarding claims, eligibility inquiries and authorization requests.

**How to Register**
Access the secure portal from the [www.wellcare.com](http://www.wellcare.com) home page by selecting the appropriate state from the drop-down menu and clicking on “Secure Login” in the “Providers” drop-down menu. For additional details, refer to the **Medicare Provider Resource Guide** found at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

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

For more information about WellCare's web capabilities, Providers may contact Provider Services or their Provider Relations representative.

**Additional Resources**
The **Medicare Resource Guide** contains information about WellCare’s secure online Provider Portal, Member eligibility, authorizations, filing paper and electronic claims, appeals and more. For more specific instructions on how to complete day-to-day administrative tasks, please see the **Medicare Resource Guide**.

Another valuable resource is the **Quick Reference Guide**, which contains important addresses, phone/fax numbers and authorization requirements. Both documents are on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

In accordance with generally accepted professional standards, participating Medicare Providers must:

- Meet the requirements of all applicable state and federal laws and regulations, including without limitation, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973
- Agree to cooperate with WellCare in its efforts to monitor compliance with its MA contract(s) and/or MA rules and regulations, and assist WellCare in complying with corrective action plans necessary to comply with such rules and regulations
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to WellCare Members as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii)]
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNPs) should provide direct Member care within the scope or practice established by the rules and regulations of the state and WellCare guidelines
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations
- Clearly identify their title (examples: M.D., D.O., 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 treatment for any Member in need of health care services they provide
- Respond within the identified timeframe to WellCare’s requests for medical records in order to comply with regulatory requirements
- Maintain accurate medical records and adhere to all WellCare policies governing the content and confidentiality of medical records as outlined in Section 3: Quality Improvement and Section 8: Compliance
- Allow WellCare to use Provider performance data for quality improvement activities
- Cooperate with QI activities
- Ensure that:
  - All employed physicians and other health care practitioners and Providers comply with the terms and conditions of the Agreement
  - To the extent the physician maintains written agreements with employed physicians and other health care practitioners and Providers, such agreements must be consistent with and require adherence to the Agreement
  - The physician maintains written agreements with all contracted physicians or other health care practitioners and Providers, which agreements must be consistent with and require adherence to the Agreement
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the Member, or the requesting party at no charge, unless otherwise agreed
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen
- Not discriminate in any manner between WellCare MA Members and non-WellCare MA Members
- The hours of operation offered to WellCare Members are no less than those offered to commercial Members
- Not deny, limit, or condition the furnishing of treatment to any WellCare MA Member on the basis of any factor that is related to health status, including, but not limited to the following:
  - Medical condition, including behavioral as well as physical illness
  - Claims experience
  - Receipt of health care
  - Medical history
  - Genetic information
  - Evidence of insurability, including conditions arising out of acts of domestic violence
  - Disability
- Freely communicate with and advise Members regarding the diagnosis of the Member’s condition and advocate on the Member’s behalf for the Member’s health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services
- Identify Members who are in need of services related to domestic violence, smoking cessation or substance abuse. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs
- Must document the referral to WellCare-sponsored or community-based programs in the Member’s medical record and provide the appropriate follow-up to ensure the Member accessed the services

**Responsibilities of All Providers**
The following is a summary of the responsibilities of all Providers who render services to WellCare Members.

**Marketing Medicare Advantage Plans**
Medicare Advantage plan marketing is regulated by the Centers for Medicare and Medicaid Services (CMS). Providers should familiarize themselves with CMS regulations and the CMS Medicare Managed Care Manual. For more information, refer to Section 8: Compliance in this Manual.

**Maximum Out-of-Pocket**
For certain MA Member benefit plans, Member expenses are limited by a maximum out-of-pocket (MOOP) amount. If a Member has reached the maximum out-of-pocket amount for that particular Member’s benefit plan, a Provider should not collect any additional out of pocket amounts from the Member and should not apply or deduct any Member expenses from that Provider’s reimbursement. Providers may determine a Member’s accumulated out-of-pocket amount via the Provider Portal or by contacting WellCare’s Provider Services Department. In the event a Provider collects an out-of-pocket amount that causes a Member to exceed his or her annual maximum out of pocket, WellCare will notify the Provider of the Member and the amount that was collected in excess of the maximum out-of-pocket and the Provider shall promptly reimburse the Member for that amount.
If WellCare determines that the Provider did not reimburse the amount in excess of the maximum out-of-pocket amount to the Member, WellCare may pay the overage amount to the Member directly, and recoup the amount from the Provider. If WellCare has deducted any Member expenses from the Provider’s reimbursement in excess of the Member’s maximum out-of-pocket amount, WellCare will reimburse the Provider for the excess amount deducted so long as that amount is not owed to the Member.

WellCare may audit the Provider’s compliance with this section and may require the Provider to submit documentation to WellCare demonstrating that the Provider reimbursed Members for amounts in excess of the maximum out-of-pocket amounts.

**Deductible**

Some Medicare benefit plans require Members to meet a Part B deductible each year for certain services before they may receive any payment from the health plan. Members who enroll after January of each year may have already met their deductible at another health plan. When Providers become aware that this has occurred, they should notify WellCare and provide documentation illustrating that the Member has met his or her deductible. For example, a Provider might submit a remittance from the state or another health plan illustrating that the Member met the Member’s deductible previously. If appropriate documentation is submitted and approved, WellCare will readjudicate the claim and pay the Provider.

When the Member’s benefit plan includes a Part B deductible, it will be applied to payments that would otherwise be made for the following services:

- Cardiac rehabilitation services
- Intensive cardiac rehabilitation services
- Pulmonary rehabilitation services
- Partial hospitalization
- Chiropractic services
- Occupational therapy services (Except in GA)
- Physician specialist services
- Outpatient behavioral health specialty services
- Podiatry services
- Other health care professional
- Psychiatric services
- Physical therapy and speech-language pathology services (Except in GA)
- Medicare covered outpatient diagnostic procedures/tests & lab services
- Diagnostic radiological services
- Therapeutic radiological services
- Outpatient X-Rays
- Outpatient hospital services
- Ambulatory surgical center (ASC) services
- Outpatient substance abuse
- Outpatient blood services
- Ambulance services
- Durable medical equipment (DME)
- Prosthetics/medical supplies
- End-stage renal disease
- Kidney disease education services
- Diabetes self-management training
Advance Directives
Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Advance Directives may differ among states.

Each Member (age 18 years or older and of sound mind), should receive information regarding Advance Directives. These directives allow the Member to designate another person to make medical decisions on the Member’s behalf should the Member become incapacitated.

Information regarding 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.

Providers shall not, as a condition of treatment, require a Member to execute or waive an Advance Directive.

Provider Billing and Address Changes
Providers are required to give prior notice (thirty day advance notice is recommended) for any of the following changes. Please contact us at 1-855-538-0454 to report changes to your:

- 1099 mailing address
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and fax number
- Panel status (open/closed)

Failure to notify WellCare prior to these changes will result in a delay in claims processing and payment.

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

- Any contracted Provider must give at least 90 days prior written notice (180 days for a hospital) to WellCare before terminating their relationship with WellCare “without cause,” unless otherwise agreed to in writing. This ensures adequate notice may be given to WellCare Members regarding the Provider’s participation status with WellCare. Please refer to the Agreement for the details regarding the specific required days for providing termination notice, as Providers may be required by contract to give more notice than listed above
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month

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

WellCare 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 as required by Medicare Advantage program requirements and/or regulations and statutes.
Out-of-Area Member Transfers
Providers should assist WellCare in arranging and accepting the transfer of Members receiving care out of the service area if the transfer is considered medically acceptable by a WellCare Provider and the out-of-network attending physician/Provider.

Members with Special Health Care Needs
A Member with “special health care needs” is a Member who has one or more of the following conditions:

- Intellectual Disability or related conditions
- Serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia or degenerative neurological disorders
- Disabilities resulting from chronic illness such as arthritis, emphysema or diabetes; or
- Environmental risk factors such as homelessness or family problems that may lead to the need for placement in foster care

Providers who render services to Members with special health care needs shall:

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

Access Standards
All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member’s needs.

WellCare shall monitor Providers against the standards below to ensure Members can obtain needed health services within acceptable appointment, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP – Urgent</td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td>PCP – Non-urgent</td>
<td>&lt; 1 week</td>
</tr>
<tr>
<td>PCP – Routine</td>
<td>&lt; 30 days</td>
</tr>
<tr>
<td>Specialist</td>
<td>&lt; 30 days</td>
</tr>
</tbody>
</table>

In-office wait times shall not exceed 30 minutes.
PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week. To ensure access and availability, PCPs must provide one of the following:

- A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP
- Answering system with option to page the physician for a return call within a maximum of 30 minutes
- A nurse who will answer after hours calls and provide the Member with access to the PCP or on-call physician within a maximum of 30 minutes

Please see Section 11: Behavioral Health for behavioral health and substance use access standards.

Responsibilities of Primary Care Providers
The following is a summary of responsibilities specific to PCPs who render services to WellCare Members. Coordinate, monitor and supervise the delivery of primary care services to each Member:

- See Members for an initial office visit and assessment within the first 90 days of enrollment in WellCare
- Assure Members are aware of the availability of public transportation where applicable Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of the PCP and any organization that (a) owns or controls the PCP’s operation, (b) has a financial relationship with the PCP, or renders services to the PCP’s office\Submit an encounter to WellCare for each visit in which the Provider sees the Member and the Member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. For more information on encounters, refer to Section 5: Claims in this ManualEnsure Members utilize network Providers. If unable to locate a WellCare-participating Medicare Advantage Provider for services required, Providers should call the Clinical Services Department phone number listed in the Quick Reference Guide on WellCare’s website for assistance Implement corrective action and performance improvement plan(s) when required by WellCare

Primary Care Offices
PCPs provide comprehensive primary care services to WellCare Members. Primary care offices participating in WellCare’s Provider network have access to the following resources:

- Support of WellCare’s Provider Relations, Provider Services, Clinical Services
- The tools and resources available on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu
- Information on WellCare network Providers for the purposes of referral management and discharge planning

Closing of Provider Panel
When requesting closure of their panel to new Members and/or transferring WellCare Members, PCPs must:

- Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel
- Keep the panel open for WellCare Members who were provided services before the closing of the panel
- Notify WellCare when reopening the panel and provide the effective date
Covering Physicians/Providers
In the event that a PCP’s covering Provider is temporarily unavailable, the PCP should make arrangements with another Provider who participates in WellCare’s Medicare Advantage program. In the event of an emergency, Members may seek care from any Provider – regardless of whether the Provider is contracted with WellCare.

In non-emergency cases, Providers should contact WellCare for approval of any covering physician/Provider who is not contracted with WellCare or has not been credentialed by WellCare. For more information, refer to the state-specific Quick Reference Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

Assignment of Primary Care Provider
All Members will choose a PCP or one will be assigned to the Member. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Member’s health care needs, including providing primary care services and coordinating referrals to specialists and Providers of ancillary or hospital services.

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

Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. In the event that a participating Provider desires to terminate his or her relationship with a Member, the Provider must complete a PCP Request for Transfer of Member form, attach documentation of the Member’s non-compliance with treatment or uncooperative behavior that is impairing the ability to care for and treat the Member effectively. The form should be faxed to WellCare’s Provider Services Department. The Request for transfer of Member form is on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Forms” under “Medicare” in the “Providers” drop-down menu.

Once the form has been submitted, the Provider shall continue to provide medical care for the Member until such time that written notification is received from WellCare confirming that the Member has been successfully transferred to another Provider.

Domestic Violence and Substance Abuse Screening
PCPs should identify indicators of substance abuse or domestic violence, and report suspected abuse via WellCare’s FWA Hotline at 1-866-678-8355. Sample screening tools for domestic violence and substance abuse are located on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Clinical Guidelines” under “Tools” in the “Providers” drop-down menu.

Smoking Cessation
PCPs should direct Members who wish to quit smoking to call WellCare’s Customer Service Department and ask to be directed to the Care Management Department. A care manager will educate the Member on national and community resources that offer assistance, as well as smoking cessation options available to the Member through WellCare.
Adult Health Screening
An adult health screening should be performed by a Provider to assess the health status of all WellCare MA Members. The adult Member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines and the Member physical screening tool, both located on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Clinical Guidelines” under “Tools” in the “Providers” drop-down menu.

Cultural Competency Program and Plan

The purpose of the Cultural Competency program is to ensure that WellCare meets the unique, diverse needs of Members, values diversity within the organization, and identifies Members in need of linguistic services and has adequate communication support for such Members. Providers shall recognize and make arrangements to 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
- Utilize culturally sensitive and appropriate educational materials based on the Member’s race, ethnicity and primary language spoken
- Make resources available to meet 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
- Decrease health care disparities in the minority populations WellCare serves

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

The components of WellCare’s Cultural Competency program include:
- Data analysis
  - Analysis of claims and encounter data to identify the health care needs of the population
  - Collection of Member data on race, ethnicity and language spoken
- Community-Based Support
  - Outreach to community-based organizations which support minorities and the disabled in ensuring that the existing resources for Members are being utilized to their full potential
- Diversity
  - Non-Discriminating – WellCare may not discriminate with regard to race, religion or ethnic background when hiring associates
  - Recruiting – WellCare recruits diverse talented associates in all levels of management
  - Multilingual – WellCare recruits bilingual associates for areas that have direct contact with Members to meet the needs identified and encourages Providers to do the same
• Diversity of Provider Network
  o Providers are inventoried for their language abilities and this information is made available in the Provider Directory so that Members can choose a Provider that speaks their primary language
  o Providers are recruited to ensure a diverse selection of Providers to care for the population served

• Linguistic Services
  o Providers will identify Members who have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance
  o Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service Department
  o Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by WellCare’s Customer Service Department
  o Written materials are available for Members in large print format and certain non-English languages, prevalent in WellCare’s service areas

• Electronic Media
  o Telephone system adaptations - Members have access to the TTY line for hearing impaired services. WellCare’s Customer Service Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY number can be found on the Member identification card

• Provider Education
  o WellCare’s Cultural Competency Program provides a Cultural Competency Checklist to assess the Provider office’s Cultural Competency

Registered Provider Portal users may access the Cultural Competency Program training on WellCare’s website at www.wellcare.com. A Provider may request a paper copy by calling WellCare’s Provider Services Department or contacting their Provider Relations representative.

Providers must adhere to the Cultural Competency program as set forth above.

**Cultural Competency Survey**
Providers may access the Cultural Competency Survey on WellCare’s website at www.wellcare.com.

**Member Administrative Guidelines**

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

**Evidence of Coverage Booklet**
All WellCare Members receive an Evidence of Coverage booklet no later than 10 calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later, and annually thereafter.
Enrollment
WellCare must obey laws that protect from discrimination or unfair treatment. WellCare does not discriminate based on a person’s race, disability, religion, sex, health, ethnicity, creed, age, or national origin.

Upon enrollment with WellCare, Members are provided the following:
- Terms and conditions of enrollment
- Description of covered non-emergency services in-network and out-of-network, if applicable
- Information regarding coverage of out-of-network emergency/urgent care services
- Information about PCPs, such as location, telephone number and office hours
- Grievance and disenrollment procedures
- Brochures describing certain benefits not traditionally covered by Medicare and other value-added items or services, if applicable

Member Identification Cards
Member identification cards are intended to identify WellCare Members, including the type of plan they have, and facilitate their interactions with health care Providers. Information found on the Member identification card may include the Member’s name, identification number, plan type, PCP’s name and telephone number, co-payment information, health plan contact information, and claims filing address. Possession of the Member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

Eligibility Verification
A Member’s eligibility status can change at any time. Therefore, all Providers should request and make a copy of the Member’s identification card, along with additional proof of identification such as a photo ID, and file them in the patient’s medical record.

Providers may do one of the following to verify eligibility:
- Access the Provider Portal at www.wellcare.com
- Access WellCare’s Interactive Voice Response (IVR) system
- Contact WellCare’s Provider Services Department

Providers will need their Provider ID number to access Member eligibility through the avenues listed above. Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See the Agreement for additional details.

Member Rights and Responsibilities
WellCare Members have specific rights and responsibilities when it comes to their care. The Member rights and responsibilities are provided to Members in the Member’s Evidence of Coverage booklet and are outlined below.

Members have the right to:
- Have information provided in a way that works for them including information that is available in alternate languages and formats
- Be treated with fairness, respect, and dignity
- See WellCare Providers, get Covered Services, and get their prescriptions filled in a timely manner
- Privacy and to have their protected health information (PHI) protected
• Information about WellCare, its network of Providers and practitioners, their Covered Services, and their rights and responsibilities
• Know their treatment choices and participate in decisions about their health care
• Use Advance Directives (such as a living will or a durable health care power of attorney)
• Make complaints about WellCare or the care provided and feel confident it will not affect the way they are treated
• Appeal medical or administrative decisions WellCare has made by using the grievance process
• Make recommendations about WellCare’s Member rights and responsibilities policies
• Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. The information must be given to Members in a way they understand

Members also have certain responsibilities. These include the responsibility to:
• Become familiar with their coverage and the rules they must follow to get care as a Member
• Tell WellCare and Providers if they have any additional health insurance coverage or prescription drug coverage
• Tell their PCP and other health care Providers that they are enrolled in WellCare
• Give their PCP and other Providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their Providers agree upon
• Understand their health problems and help set treatment goals that they and their doctor agree to
• Ask their PCP and other Providers questions about treatment if they do not understand.
• Make sure their doctors know all of the drugs they are taking, including over-the-counter drugs, vitamins, and supplements
• Act in a way that supports the care given to other patients and helps the smooth running of their doctor’s office, hospitals, and other offices
• Pay their plan premiums and any co-payments or coinsurance they owe for the Covered Services they get. Members must also meet their other financial responsibilities as described in the Evidence of Coverage booklet
• Inform WellCare if they move
• Inform WellCare of any questions, concerns, problems or suggestions by calling the Customer Service Department listed in their Evidence of Coverage booklet

Changing Primary Care Providers
Members may change their PCP selection at any time by calling WellCare’s Customer Service Department.

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

Hearing-Impaired, Interpreter and Sign Language Services
Hearing-impaired, interpreter and sign language services are available to WellCare Members through Customer Service. PCPs should coordinate these services for Members and contact Customer Service if assistance is needed. For Provider Services phone numbers, please refer
to the state-specific Quick Reference Guides at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.
Section 3: Quality Improvement

Overview
The Quality Improvement (QI) Program is comprehensive, systematic and continuous. It applies to all Member demographic groups, care settings, and types of services afforded to Medicare Advantage Members, including the Dual Special Needs Plan membership. The QI Program addresses the quality of clinical care and non-clinical aspects of service. Key areas of focus include, but are not limited to:

- Utilization management
- Care management/ disease management
- Quality Improvement projects
- Chronic care improvement projects
- Network adequacy
- Preventive and clinical health
- Quality of care and service utilization
- Coordination and continuity of care
- Cultural competency
- Credentialing
- Appeals and grievances
- Member and provider satisfaction
- Components of operational service
- Contractual, regulatory and accreditation reporting requirements

The QI Program reflects a continuous quality improvement (CQI) philosophy and mode of action. CQI processes identified in the QI Program Description, Work Plan and Annual Evaluation are approved by the applicable Committees and conducted to accomplish identified goals. The QI Program Description defines program structure, accountabilities, scope, responsibilities, and available resources.

The annual QI Work Plan identifies specific activities and projects to be undertaken by WellCare and the performance measures to be evaluated throughout the year. Work Plan activities align with contractual, accreditation and/or regulatory requirements and identify measurements to accomplish goals. The Annual QI Evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and prior years trending as appropriate. The Annual Evaluation describes the overall effectiveness of the QI Program by including:

- A description of ongoing and completed QI activities and projects
- Trended clinical care and service performance measures as well as the desired outcomes and progress toward achieving goals
- An analysis of accomplishments in the quality of clinical care and service
- Current opportunities for improvement with recommendations for interventions

Each QI process is continually improved by analyzing and acting to ensure consistency across the enterprise, thus becoming more efficient and effective. The Plan-Do-Study-Act (PDSA) method of CQI is utilized throughout the organization. Under the PDSA approach multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care and service delivery. When variations are noted, root cause analysis, action plans and re-measurement occur to ensure progress toward established goals.
The CQI strategy noted above is demonstrated in the structure of the QI Program’s committees and sub-committees, the QI Program Description, Work Plan and Annual Evaluation. The strategy incorporates the continuous tracking and trending of quality indicators to ensure outcomes are being measured and goals are attained. Monitoring of quality of care interventions and outcomes through HEDIS® measure reviews, external quality review studies, periodic medical record reviews (for chart maintenance, documentation legibility, disease management compliance, continuity of care coordination, information security) and as required by CMS.

**Program Methodology**

The QI Program methodology involves a review of the complete range of health services provided to Members as categorized by all demographic groups, including those with special healthcare needs, clinically related groups, and service settings for clinical and non-clinical measures.

The QI Program is based on the latest available research in the area of quality assurance and at a minimum includes a method of monitoring, analysis, evaluation and improvement in delivering quality care and service. The QI Program involves tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are attained. Federal and state contractual standards, evidence-based practice guidelines, and other nationally recognized sources such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Health Outcomes Survey (HOS) and The Healthcare Effectiveness Data and Information Set (HEDIS®) may be utilized to identify performance/metric indicators, standards, and benchmarks. Indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable). The indicators may reflect, without limitation, the following parameters of quality:

- **Structure, process, or outcome of care**
- **Administrative and care systems within clinical services which may include the following:**
  - Acute and chronic condition management
  - Care management
  - Disease management
  - Utilization management
  - Credentialing
  - Member and Provider satisfaction
  - Medical record review
  - Member complaints and appeals
  - Practitioner availability and accessibility
  - Plan accessibility
  - Member safety
  - Preventive care
  - Disparities in care

HEDIS® measures and CAHPS® and HOS results are integrated in the QI Program. HEDIS® measures and methodology may be adopted as performance indicators for clinical improvement. The CAHPS® survey is utilized as one of the tools for assessing Member satisfaction. The HOS is used to assess the Member’s physical and mental well-being at the beginning and end of a two-year cycle.

Quality initiatives are developed and implemented as indicated by data analysis for process improvements. Initiatives are reassessed on an annual basis to evaluate intervention effectiveness and compare year-to-year performance.
Data Collection Process for Performance Measure Evaluation
Data is collected on a routine basis (monthly, quarterly, and/or annually) and on an ad hoc basis from internal and external sources to systematically and objectively monitor, analyze, evaluate, and report health outcomes and indices of quality. Data collection follows protocols established in approved policies or QI program design. Data related to all aspects of Member services, departmental operations and outcomes may be collected.

Data Sources
Data sources may be administrative, surveys, medical records, or a combination. Data sources may include, without limitation: Enrollment information, claims, encounters, authorizations, appeals, complaints, disease/Care management documentation, access and availability survey findings, Member medical records within Provider offices and facilities, surveys by external bodies such as accreditation entities or CMS, QI studies, CAHPS®, HOS and HEDIS® results.

Data sources may also include a review of Member medical records within Provider offices and facilities and surveys by external bodies such as accreditation entities or CMS, QI studies, HOS, CAHPS®, and HEDIS® results as well as Standard and Process standards.

WellCare integrates data from multiple sources to produce clinically relevant data on an ongoing basis for quality reporting. WellCare utilizes a software system and all data is entered into the system electronically. This program is used for HEDIS® reporting on a monthly, quarterly and annual basis. This software is certified by the National Committee for Quality Assurance (NCQA) for HEDIS® data reporting and can accommodate other quality studies as needed by WellCare.

On a monthly basis, the system is refreshed and WellCare reviews the volume of data by submitter to ensure data is coming in and is being captured for quality reporting. In addition, HEDIS® reports are run monthly and HEDIS® Provider Profiles are produced which track and trend Provider HEDIS® rates. This enables WellCare to conduct follow up with high volume and other key Providers/Provider groups for education regarding HEDIS rates, benchmarking for comparison to peers, the overall plan rate and the NCQA thresholds.

WellCare contracts with an NCQA-certified HEDIS® auditing organization, who conducts the annual HEDIS® audit using NCQA’s standardized audit methodology. The external HEDIS® auditor adds a higher degree of integrity to HEDIS® data and enables WellCare to provide consumers and purchasers with consistent and comparable HEDIS® reports.

WellCare contracts with an NCQA-certified survey vendor to conduct the HOS on an annual basis dependent upon the cohort of each health plan. HOS data is evaluated to determine areas of needed improvement and the needs of the population served under the Medicare Advantage program. The HOS is used to assess the Member’s physical and mental well-being at the beginning and end of a two-year cycle. HOS results are presented to the relevant quality committee to obtain input from the network participating Providers. As data is evaluated initiatives are identified to improve the health outcomes of WellCare’s beneficiaries.

As it relates to CAHPS®, WellCare contracts with an NCQA-certified survey vendor to conduct the CAHPS® on an annual basis. CAHPS® results are presented to the Medical Advisory Committee to obtain input from the network participating Providers and to the Quality Improvement Committee (QIC). As data is evaluated initiatives are identified to improve the health outcomes of WellCare’s beneficiaries.
WellCare collects and reports Structure and Process Measures as a cross functional and collaborative effort. Information is collected and housed in a shared drive, reviewed by the QIC and uploaded to NCQA. The Medical Economics Department run reports identified for the NCQA submission and provide each functional area with data as necessary.

WellCare’s Care Management Department and QIC review information received from all functional areas and assure accuracy and completeness. Structure and Process Measure comments and recommendations by NCQA auditors are distributed to the appropriate functional area(s) for review, development of process improvement activities/interventions, implementation of activities, and ongoing monitoring/evaluation for outcomes.

WellCare identifies its most vulnerable subpopulations by utilizing an algorithm which incorporates medical, behavioral, and pharmaceutical claims and encounter data. Each Member identified by the algorithm is assigned a score based on three primary drivers: severity, utilization and cost. In addition to being assigned a score, Members are flagged when specific chronic conditions exist.

Severity is based on the model *Chronic Illness and Disability Payment* (CDPS), a diagnostic classification system. This model classifies every diagnosis code on a claim and assigns a score based on the severity of the diagnosis.

The model uses a number of utilization indicators and applies a weighted count. The metrics tracked include: hospital admissions, ER visits, PCP visits, specialty visits, acute admissions, home health visits, and rehab visits. Internal and external referrals, to include Member self-referral, are additional sources utilized to identify the population with complex illnesses and/or special needs. Data mining is an ongoing process.

**Data Collection Methodology**

Data collection is the responsibility of the department or functional area conducting the related QI activity. Medical data collected manually is completed by qualified staff (i.e. data extraction from medical records is completed by, or under the direction of licensed personnel). If data collection includes a medical decision rendered by a physician then the collection must be performed by a physician. Data collection follows protocols established in approved policies or program design. Manual data collection tools ensure consistent and accurate abstraction of data per indicator/written specifications. Inter-rater reliability is evaluated for all manual data abstraction processes. There is a written, systematic step sequence process for all administrative data collections. Administrative data completeness and accuracy is identified when reporting data collection and/or findings.

**Sampling Methodology**

The sample selected is based on the indicator or measure being evaluated and identified in the written documentation of monitoring activities. Statistically valid sampling is utilized for data collection when appropriate. HEDIS® specifications are utilized as applicable.

**Frequency of Data Collection**

Data is collected systematically at specified intervals i.e. daily, weekly, monthly, quarterly, semi-annually, annually, or on an ad hoc basis. The collection/reporting frequency is included in the work plan for each measure. Data results are reported on a metric grid and presented to the relevant quality committee.
Data Accuracy and Completeness
There is a written, systematic step sequence process for all administrative data collections. Administrative data completeness and accuracy is identified when reporting data collection and/or findings. Data relating to the Medicare Advantage program activities are captured as needed on standardized documentation forms, such as meeting minutes and action registers, to facilitate both internal and external communication and to promote focus on improvement priorities.

Monthly the system is refreshed and WellCare reviews the volume of data by submitter to ensure data is appropriately entered and captured for Quality reporting. In addition, HEDIS® reports are run monthly and HEDIS® Provider Profiles are generated to track and trend Provider specific rates. WellCare conducts follow up with high volume Providers regarding HEDIS® rates and their benchmark in comparison to peers, WellCare rate and the NCQA thresholds.

WellCare contracts with an NCQA-certified HEDIS® auditing organization, who conducts the annual HEDIS® audit using NCQA’s standardized audit methodology. The external HEDIS® auditor adds a higher degree of integrity to HEDIS® data and enables WellCare to provide consumers and purchasers with consistent and comparable HEDIS reports.

Qualified staff complete all manual collection of data (i.e. data extraction from medical records is completed by, or under the direction of licensed personnel). Data collection follows protocols established in approved policies or program design. Standardized manual data collection tools ensure consistent and accurate abstraction of data per indicator/written specifications. Inter-rater reliability is evaluated for all manual data abstraction processes.

Data reports are run are on a monthly, quarterly and/or annual basis and statistical analysis is conducted. Barrier root cause analysis is conducted to develop interventions to address deficiencies identified. Results are presented to the QIC for review, discussion, identification of interventions, and report approval.

To ensure accuracy and completeness of structure and process data all Care Management staff receives initial training regarding the internal data system, conducting the assessments and documentation.

Internal audits are conducted on a monthly basis to ensure appropriate/accurate data is captured by the care manager. A minimum number of files are reviewed and findings are discussed with the care manager. Coaching and additional training is conducted when deficiencies are identified.

Data and Record Maintenance
All data collected is maintained for a period of 10 years as required by CMS, or longer as required. Electronic data from claims and encounters is stored in the internal electronic system and is available for query for an unlimited period of time. All queries used to produce data are stored on shared drives and version controlled to allow for replication of data. Data is backed up nightly and back-up tapes are archived on an ongoing basis.

QIC, sub-committee agendas, minutes, action registers, Quality Improvement Projects (QIPs), annual evaluations and work plans are maintained electronically and in hard copy to have available as needed for CMS.
Member data is housed in EMMA (Enterprise Medical Management Application) for use by care managers, coordinators, social workers and nurses as needed for care/disease management and utilization, including quality of care review.

**Data Analysis for Performance Measure Evaluation**
Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving WellCare’s clinical and service performance goals. These analyses will take into account, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance. Revisions to the Work Plan may be initiated as a result of findings or reprioritization of projects and new events.

Analyses and QI Program reports are communicated to the QIC and UMAC. Summary reports are presented to the Board. The QI Program Description and initiative outcomes are available to Providers and Members upon request. An annual summary of the QI Program Evaluation is presented in the Member and Provider newsletters. The QIC and MAC have a responsibility to disseminate information regarding QI Program activities and outcomes internally to staff Members.

**Quality Improvement Activities**
A critical component of the WellCare QI Program is in regard to the identification and collection of data that is meaningful and relevant to the population served. Continuing through the PDSA QI process, outcomes, limitations and barriers to goal attainment are identified, strategic planning is conducted and interventions are implemented. Goals and objectives are identified and revised through a continuation of these activities with the knowledge that for some Member’s health outcomes may involve a continuation versus deterioration of health status, completion of recommended preventive screenings, a safe living environment or the timely access to appropriate medical and behavioral health care.

The initial data sources utilized in the QI process for Members include the Health Risk Assessment (HRA), Comprehensive Medical Assessment and individualized plan of care which also addresses behavioral health care needs. Since care management services are offered to all eligible Members this is the most readily available data for new Members. In addition, the initial communication and ongoing collaboration with treating Providers is an integral and invaluable data source and component of the process to improve Member outcomes. Additional data sources are utilized as data is available and are noted in the subsequent section.

QI Program Activities may be identified through a review of clinical and non-clinical service population data. For established programs, HEDIS® data is recognized through the industry as a publicly reported measure of the quality of care Members receive. HEDIS® data is routinely monitored to identify QI activities relevant to the population for which interventions have the potential to impact Member outcomes.

HEDIS® data is benchmarked against the NCQA benchmarks and thresholds to determine areas of improvement needed. A root cause analysis is performed to determine barriers. HEDIS® results and root cause analysis are analyzed and reviewed at the Medical Advisory Committee for input from network participating Providers. The results are then reviewed at the QIC and action plans are developed to create initiatives to ensure sustained improvement in the measures. HEDIS® data is reviewed monthly and quarterly throughout the year to make adjustments in initiatives to ensure Members are receiving the care they require.
Reports of Structure and Process measure results are reviewed and analyzed within the Care Management and other applicable WellCare departments and the QIC. Workgroups are utilized to identify and implement appropriate interventions for process improvement.

**Data Analysis and Evaluation**
Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving WellCare’s clinical and service performance goals. These analyses will take into account, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance. Revisions to the Work Plan may be initiated as a result of findings or reprioritization of projects and new events.

Analyses and QI Program reports are communicated to the relevant quality committee. Summary reports are presented to the Board. The QI Program Description and initiative outcomes are available to Providers and Members upon request. An annual summary of the QI Program Evaluation is presented in the Member and Provider newsletters. The QIC has a responsibility to disseminate information regarding QI Program activities and outcomes internally to staff members.

**Data Analysis and Quality Improvement Projects (QIPs)**
42CFR §422.152(c)-(d)
QI activities are not limited to those that will improve compliance with a contractual or regulatory requirement. Any individual, functional area or department within the WellCare system may identify and design/develop a formal or informal QI activity. The activity may be the result of identification of an issue or the desire to improve performance of a particular function. Proposed QI activities are presented for review and approval by the QIC.

QIP initiatives are determined by their relevancy to the Medicare Member population. WellCare may utilize HEDIS results, quality outcomes, indices of quality, customer service metrics, HOS and customer satisfaction to determine the needs of the Members for QI activities. The metrics are reviewed by WellCare’s Medical Advisory Committee and QIC to determine which metrics may influence WellCare’s goal of standardizing care, improving processes and outcomes of health care or services and have a potentially significant impact on beneficiaries’ health, functional status or satisfaction.

Once an aspect of clinical care or non-clinical care that warrants QI is identified the goals of a QIP would include:
- Determination of a benchmark that reflects established performance through comparative data to support the basis on which the goal was established such as HEDIS® percentile thresholds, nationally-recognized clinical practice guidelines, literature search for nationally published benchmarks, AHRQ or Healthy People 2020
- Collection of baseline data
- Conducting a barrier analysis to assist in determining the appropriate interventions to improve performance
- Implementing interventions
- Conducting a re-measurement at predetermined intervals, adjusting interventions if needed and ultimately achieving significant improvement sustained over time

WellCare initiatives to improve service and health outcomes of Members include the initiation and evaluation of QIPs that focus on clinical and non-clinical topics relevant to the population with the ability to impact change for improvements. WellCare may utilize HEDIS® results, quality
outcomes, indices of quality, customer service metrics, HOS and customer satisfaction to determine the needs of the Members for QI activities. Data may be collected at specified intervals i.e. ongoing, ad hoc, monthly, semi-annually, but at a minimum annually. Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving clinical and/or service performance goals. Barriers for achieving desired outcomes and interventions or strategies recommended are considered in the analysis. Data is aggregated to track and trend over time for identification of optimal and sub-optimal plan performance. Based on the analysis of the results, new interventions or current interventions may be revised.

The metrics are reviewed by WellCare’s Medical Advisory Committee and QIC to determine which metrics may influence WellCare’s goal of standardizing care, improving processes and outcomes of health care or services and have a potentially significant impact on beneficiaries’ health, functional status or satisfaction.

QI project indicators are objective and measurable, methodology is statistically valid, and re-measurement occurs at specified intervals, i.e. ongoing, ad hoc, monthly, semi-annually, but at a minimum annually through the HEDIS® Effectiveness of Care Measures results or the quality indices and outcomes measurements. Benchmarks are used to determine the effectiveness of interventions and identify trends and opportunities for improvement. The source of the benchmark may be identified using NCQA HEDIS® Percentiles, CPGs, AHRQ, and Healthy People 2020. Measurement results are reviewed by appropriate staff, barrier analysis to achieving desired goal is conducted and interventions implemented. WellCare’s interventions may be system-wide or population specific and include the establishment or alteration of practice guidelines as appropriate. The QIC reviews and approves all QIPs. Status reports and results of QI projects are available when requested.

QIPs are initiated and/or sustained on an annual basis in alignment with requirements noted in the Medicare Managed Care Manual.

For HEDIS® metrics, WellCare utilizes the current HEDIS® Technical Specifications to identify beneficiaries for QIPs. WellCare uses NCQA-certified software to run the source code to identify Members monthly. Standard coding guidelines are utilized as appropriate. Data reports are generated periodically to monitor the population affected by these outcome metrics.

**Data Reporting**

WellCare has implemented the Part C Technical Specifications provided by CMS for the data measure as it relates to its Part C Reporting Requirement. The respective WellCare Functional Area (WFA) will collect data, whether internal or external (Delegated Entity), and validate that data, which may include, but is not limited to, validation of databases used in preparing and or housing any data, comparing to prior reports for trend analysis, and ensuring it meets the current CMS Validation Standards by aligning to various tools such as the OAI (Organizational Assessment Instrument). Additionally, an Enterprise Compliance System is purported to capture the data and associated WFA attestations, where it will then be reviewed further by Regulatory Affairs and Medicare Compliance and Audit.

WellCare ensures accuracy of the data elements by ensuring alignment to the OAI, various validation standards of both an internal and external nature, varying levels of subsequent analysis of data by different groups, and overall adherence to the CMS Data Validation Standards.
Operationally, data is reviewed / analyzed by the WFA, and consequently, steps are taken to increase performance outcomes and overall improvement of the Model of Care program.

WellCare collects and reports HEDIS® and Structure and Process measure data annually for all Medicare plans with 30 or more Members. Data is primarily extracted from documentation in the EMMA system by the Medical Economics Department and reported to the Care Management Department. Cross functional areas within WellCare collaborate to gather the information, documents and reports for submission. Other sources for which information is collected include, but are not limited to Member and Provider brochures, policies and procedures.

WellCare participates in the CAHPS® and HOS as required by CMS on an annual basis. WellCare contracts with an NCQA-certified survey vendor to conduct the HOS survey on all plans required to collect and report CAHPS and HOS data. The survey vendor utilizes the NCQA-required survey techniques and follows the specifications as required by NCQA. WellCare works with the survey vendor to ensure the data is collected timely and appropriately. The results are then sent to CMS via the survey vendor who in turn reports the information to WellCare.

Annually, CAHPS® and HOS data is evaluated to determine areas of needed improvement and the needs of the population served under the Medicare program. The HOS is used to assess the Member’s physical and mental well-being at the beginning and end of a two year cycle.

The CAHPS® and HOS results are presented to the Medical Advisory Committee to obtain input from the network participating Providers regarding the needs of the population served based on deficiencies and areas of opportunity identified. As data is evaluated initiatives are put into place to improve the health outcomes of WellCare’s beneficiaries. Action plans are developed to address the deficiencies and identify areas of needed improvement. The data and action plans are evaluated by the QIC for approval.

**Coordination of QI Program Activity**

QI Program goals are accomplished through collaboration and coordination of resources at both the WellCare corporate and local market levels. The following activities are predominantly performed at WellCare’s corporate location in Tampa, Florida:

1) QI Program policy and procedure development
2) QI Program data collection and preliminary analysis
3) HEDIS® data collection and reporting
4) Utilization, care and disease management
5) Medical and behavioral health care necessity review criteria development and application
6) New technology evaluation, including pharmacological therapies
7) Complaint/Grievance processing
8) Appeal processing
9) Credentialing and recredentialing, including preparation of Provider files and related reporting to required agencies as appropriate
10) Geo-Access mapping and reporting
11) Appointment availability surveys
12) Member and Provider call center operations
13) Marketing operations
Work products resulting from the above WellCare corporate processes that require local market approval, are presented to WellCare QIC or appropriate local market committee and integrated into daily local market QI Department functions.

**Key Program Components**
The QI Program is designed to improve the quality and safety of health care and services delivered to WellCare Members. Clinical and non-clinical QI projects are conducted annually. Core quality indicator metrics are monitored and reported on a quarterly basis to the appropriate QI committee (Local Market Subcommittee and/or Corporate Committee), for benchmarking, identification of trends and opportunities for improvement. The key quality initiatives of the QI Program are described in the following paragraphs, with additional protocols and process requirements being detailed in applicable Program policies and procedures.

**Access/Availability Monitoring**
Access and availability is monitored at a minimum on an annual basis and as needed to ensure adequate Provider accessibility for WellCare Members and anticipated Medicare enrollment. The Geo-Access report evaluates Member-driving distance to PCP, specialists, ancillary Providers and hospitals as well as monitoring Member to practitioner ratio reports. WellCare also conducts quarterly Provider audits to measure appointment wait time for specific types of visits and Provider types. In addition, average speed of answer, hold times and call abandonment rates are monitored on an ongoing basis to assure adequate access to WellCare personnel for Members and Providers. Access and availability is also monitored on an annual basis via the Member satisfaction survey.

**Clinical Practice Guideline Development and Review**
Based on the health care needs of the Member population and opportunities for improvement identified through the QI Program, clinical practice guidelines are adopted by WellCare. These guidelines are reviewed, revised and approved at least every two years, using nationally-recognized evidenced-based literature. The guidelines are developed with input from community physicians via the UMAC. Member education material, benefit plans and coverage parameters are reviewed against the guidelines annually to ensure consistency. Annually, compliance with at least two clinical practice guidelines is reviewed. The guidelines are disseminated to Members and physicians via newsletter articles and also via WellCare’s website.

**Concerns/Complaints/Grievances**
Members, practitioners, and Providers are encouraged to contact WellCare to report issues. Concerns can be reported via telephone, the website or in writing. Issues are documented in a common database to enable appropriate classification, timely investigation and accurate reporting of issues to the appropriate quality committee. Trended data is reviewed on a periodic basis to determine if a need for further action exists, be it WellCare, practitioner, or Provider focused.

**Continuity and Coordination of Care**
WellCare’s activities encourage the PCP relationship as the Member’s Provider “home”. This strategy promotes one Provider having comprehensive knowledge of the Member’s health care needs, whether it is disease or preventive care in nature. Through contractual language and program components, PCPs are educated regarding their responsibilities.

The scope of continuity and coordination of care activities includes, but is not limited to, assessment for timely care post facility discharge, appropriate transition of Members from one level of care to another and medical record documentation that reflects presence of consultant’s notes, as appropriate.
Credentialing
Credentialing is the process by which peers evaluate an individual applicant’s background, education, training, experience, demonstrated ability, patient admitting capabilities, licensure, regulatory compliance and health status (as applicable). This evaluation is performed through primary and secondary source verifications obtained in accordance with regulatory accreditation and WellCare’s corporate policy and procedure. Information and documentation for individual practitioners or facilities is collected, verified, reviewed and evaluated, in order to approve or deny Provider network participation. Approved Providers are assigned a specialty and scope of practice that is consistent with their boards of certification, accredited training or licensure, as applicable. Specialty designations and delineation of scope of services of approved facilities is consistent with recognized industry service standards and/or standards of participation developed by WellCare corporate that may include certification, licensure, and/or accreditation, as applicable to Provider type. Re-credentialing of a Provider shall be undertaken at least every 36 months. Monitoring and evaluation of the quality and appropriateness of patient care, clinical performance, and utilization of resources of Providers is incorporated in the re-credentialing process as follows:

1) Credentialing and Re-Credentialing:
Scope of practice is reviewed as outlined in the policy and procedure. Input from the QI activities is utilized on an ongoing basis to ensure that each Provider’s scope of practice and credentials are commensurate with the Provider’s actual practice and abilities

2) Re-credentialing:
At the time of re-credentialing, in addition to information obtained through the re-credentialing application, a site survey (as applicable), findings of the primary source verification process, and relevant findings from any of the QI activities listed below may be considered components of the re-credentialing process of the practitioner or other healthcare Provider:
   a) Medical record review
   b) Diagnosis specific screens
   c) Age specific screens for preventive care
   d) Utilization review screens
   e) Sentinel events
   f) Peer review
   g) Risk management issues
   h) Member complaints and grievances
   i) Member satisfaction

Ongoing compliance with WellCare policies and procedures is assessed through a variety of methods. Providers failing to meet established standards, such as the presence of sanctions or limitations on licensure, instances of poor quality, etc., will be reviewed by the Credentialing Committee, with avenues of recourse being corrective actions, sanctions or Provider termination. Reporting to appropriate regulatory bodies will occur as needed.

Medical Record Review
Medical record review is one aspect of Provider oversight conducted to assess and improve the quality of care delivered to Members and the documentation of such care. The focus of the review may include, without limitation, patient safety or quality of care issues, clinical and/or preventive guideline compliance, HEDIS, over- and under-utilization of services, confidentiality practices and inclusion of consideration of Member input into treatment plan decisions. The review process allows for identification of the Provider’s level of compliance with
contractual, accreditation, and regulatory standards achieved. Provider training is conducted as needed to facilitate greater compliance in future assessments.

**Member Satisfaction**
Member satisfaction surveys are conducted and analyzed on an annual basis. Member complaints, grievances, and inquiries are reviewed and analyzed on a continuous basis as a measure of Member satisfaction. Low or inadequate scores are examined and a root cause analysis is completed. Opportunities for improvement are identified. Interventions such as changes in work flows and/or processes are identified and implemented to improve Member satisfaction.

**Operational Service Performance**
Statistics regarding WellCare’s status of operational performance are continuously tracked and trended. These include, but are not limited to, the call center activities and claims processing metrics. Results that are below WellCare’s designated goals initiate the development and implementation of a corrective action plan.

**Peer Review**
The medical director is responsible for peer review activities. Peer review is conducted during the investigation of quality of care or service concerns including potential compromises of Member safety. There are multiple reasons such investigations may be initiated, including adverse/sentinel events, Member complaints, over/under utilization comparisons and coordination/continuity of care statistics. The scope of the review encompasses medical, behavioral, and pharmaceutical services as applicable and determines if there is evidence of poor quality.

The Credentialing Committee functions as WellCare’s peer review committee for quality of care or conduct issues.

All aspects of peer review are deemed confidential, including findings and documents, and are protected from disclosure to the extent prescribed under state law. All persons involved with peer review activities adhere to the confidentiality guidelines applicable to medical staff committees.

Peer review may include the following:

- Evaluation of the appropriateness, adherence to standards and outcome of care generally accepted by professional group peers
- Morbidity/mortality review
- Complaints/grievances related to medical or behavioral health treatment
- Proper maintenance of medical records requirements
- Review of written and oral allegations of inappropriate or aberrant service

All peer review is documented and maintained in a locked file by the Credentialing Department. Peer review that results in a favorable determination is summarized for the Credentialing Committee on a monthly basis. Issues requiring further review, action, or disciplinary action are forwarded to the next scheduled Credentialing Committee meeting. If the issue requires immediate action, an ad hoc committee meeting is convened in accordance with policy. Any issues that are felt to be litigious in nature are referred to Risk Management immediately.
Any quality deficiencies that result in Provider suspension or termination are reported to the National Practitioner Data Bank, Department of Professional Regulation and the Department of Insurance.

The information gathered on individual Providers is compiled into a Provider profile and is submitted to the Credentialing Department for coordination with any other performance monitoring activities, including utilization review, risk management, and resolution and monitoring of Member grievances, for the purpose of re-credentialing.

**Pharmacy Program**

WellCare provides access to quality, cost effective medications for eligible beneficiaries by maintaining a network of conveniently located pharmacies. An electronic adjudication system efficiently processes prescription drug claims at the point of dispensing to confirm eligibility, make drug and benefit coverage determinations, evaluate for patient safety and adjudicate the claim with the appropriate pharmacy Provider payment. Network contracting and the adjudication of pharmacy claims are managed by a pharmacy benefit manager (PBM). WellCare has oversight of the PBM for these functions. Pharmacy provides a prescription drug formulary which is created and modified through the Pharmacy and Therapeutics (P&T) Committee. Pharmacy reviews and responds to all drug exception requests or coverage determinations (DERs) and medication appeals (redeterminations) through a formalized process that utilizes the drug formulary, prior authorization protocols and prescriber supplied documentation. Pharmacy coordinates onsite and telephonic interactions with prescribing Providers to evaluate, review and guide physician prescribing practices through a network improvement program (NIP). Emphasis is placed on the quality of care of Members through Medication Therapy Management (MTM) services as well as quality initiatives which include, but are not limited to, Member and prescriber outreach and coordinated efforts with Quality Improvement Organizations (QIOs).

It is the policy of WellCare for its Pharmacy Department to notify Members who have received a medication affected by a Class 1 and/or a Class 2 retail level recall as well as its authorized prescribers. WellCare’s Pharmacy Department shall also notify affected Members and authorized prescribers of market withdrawals.

1. Formulary Services shall receive an alert from one of the following regarding a drug recall or planned market withdrawal:
   a. The FDA via email (fda@service.govdelivery.com)
   b. Facts and Comparisons news items (online.factsandcomparisons.com)
   c. Pharmaceutical company communications to healthcare professionals

2. Formulary Services shall review the alert to determine if the recall is relevant to WellCare’s Membership. Wholesale-only drug recalls and withdrawals do not require notification of Providers or Members.

3. Formulary Services shall identify and notify Members that have received the recalled or withdrawn medication in the 90 days prior to the date the notifications were discovered.

4. Formulary Services shall notify authorized prescribers of product recalls and market withdrawals, which include voluntary withdrawals by the manufacturer and those under an FDA requirement.
5. For Class 1 Recalls, Members and authorized prescribers shall be notified within 10 calendar days of the date which WellCare discovers the recall.

6. For Class 2 Recalls, Members and authorized prescribers shall be notified within 30 calendar days of the date which WellCare discovers the recall when affected Members can be identified from batch and lot numbers.

7. For Market Withdrawals, Members and authorized prescribers shall be notified within 30 calendar days of the FDA alert when affected Members can be identified from batch and lot numbers.

**Preventive Health Guideline Development and Review**

Preventive Health Guidelines are reviewed, revised and adopted on an annual basis by the UMAC. Sources for the guidelines include the US Preventive Services Task Force guidelines and/or other evidenced-based nationally recognized guidelines. Member and Provider materials and benefit plans are reviewed for comparison with the guidelines and revised as necessary to ensure consistency. Preventive health guidelines and related educational information are disseminated to Members/Providers via handbook content, newsletter articles and WellCare’s website. Compliance with select prevention activities is evaluated annually.

**Provider Satisfaction**

An ongoing analysis of Provider complaints is conducted to evaluate Provider satisfaction. In addition, the Provider network is formally surveyed on an annual basis to assess Provider satisfaction with WellCare. Results are analyzed; an action plan is developed and implemented to address the areas identified as needing improvement. The results and action plan are presented to the UMAC and QIC for approval and recommendations.

**Sales and Marketing**

Sales and marketing activities are regulated by CMS and policies and procedures are developed to ensure all requirements are met. Sales and marketing activities are integrated in the QI Program to monitor promotional activities and ensure population needs are met from a geographic and demographic perspective. Sales and marketing reports are reviewed at least quarterly at the QIC and action plans are developed to improve Member retention and improve Member satisfaction.

**Quality Measurement Studies**

Indicators and quality management processes that are deemed to be relevant to the Member population will be considered for focused improvement study selection. Study design will be documented, and will provide a discussion of rationale, statement of a quantifiable measure, (reflecting population eligibility, known benchmarks, measurement period and goal) method for data collection, data source(s) and any plans for sampling. Meaningful actions will be taken to affect a positive result throughout the study timeframe. At the measurement period, the effectiveness of actions taken will be assessed, including an analysis of barriers to achieving the goal. Further improvement actions will be identified and presented to the QIC or appropriate subcommittee for consideration.

**Care Management/Service Coordination**

The mission of the Care Management Department is to coordinate timely, cost effective, integrated services for the individual health needs of Members to promote positive clinical outcomes. For Members who also have Medicaid with WellCare, Providers will hear this benefit being called service coordination.
Complex care management is defined as the coordination of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help in navigating the system to facilitate appropriate delivery of care and services. The goal of complex care management is to help Members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the Member’s condition; determination of available benefits and resources; and development and implementation of a care management plan with performance goals, monitoring and follow-up.

WellCare assists Members with multiple or complex conditions to obtain access to care and services, and coordinates their health care.

Members will be considered complex based on the above definition and may have any diagnosis if the Member’s medical and/or behavioral health condition require extensive coordination intervention on behalf of the care manager. Examples of the types of Members for which WellCare conducts complex care management, include, but are not limited to the following:

- Catastrophic
- Oncology
- Wound care
- Special health care needs
- Transplant
- HIV/AIDS
- Multiple chronic illnesses
- Chronic Illness that results in high utilization
- Debilitating behavioral health condition

**Disease Management**
The mission of the Disease Management (DM)/Chronic Care Improvement (CCI) Program (DM/CCI Program) is to identify Members with selected chronic diseases and provide education and health coaching to these Members and/or their caregivers to empower them to make behavior changes (i.e. avoiding triggers), self-manage their condition(s) and ensure the choices they make will improve their health and quality of life, as well as reduce the complications of their disease and medical costs.

WellCare’s DM/CCI Program provides services to Members with selected chronic conditions. The services are offered through a team of registered nurses and health professionals with clinical experience in specific diseases. The DM/CCI Program is an opt-out design which employs a population-based strategy that focuses on providing care across the continuum for Members at risk and encompasses their co-morbid conditions to ensure a holistic care approach. Elements of the Program include educating the Member about their particular condition, empowering self-management and monitoring the Member for adherence to a treatment plan, all of which are supported through the use of evidence-based clinical practice guidelines.

**Patient Safety**
The QI program includes an emphasis on patient safety. WellCare monitors aspects of the patient safety that include but are not limited to:

- Physician credentials are verified in accordance with state, federal and regulatory guidelines
• The Quality of Care program monitors potential adverse events referred from any part of the health care system
• The process of utilization management plays a vital role in the monitoring of patient safety through concurrent review, identification of potential quality of care issues, and identification of potential trends in under and over-utilization
• Member complaints are monitored for quality of care issues. These complaints are investigated and analyzed, and are referred to appropriate committee as necessary
• The Drug Utilization Review (DUR) program, alerts pharmacies of potential drug to drug interactions and adverse effects resulting from the age or gender of a Member; or other pharmacy problems at the time a prescription is filled

**Culturally and Linguistically Diverse Members**

WellCare recognizes the diversity and specific cultural needs of its Members and has identified measures to meet the cultural needs of its membership. Objectives implemented to facilitate cultural and linguistic needs include:

• Staff and network practitioners and Providers are encouraged to deliver culturally competent services
• Language assistance services are available through a language translation line and bilingual staff at no cost to those Members with limited English proficiency
• Bilingual staff are hired and retained
• Member-related materials, including conflict and grievance resolution instructions, are available in languages of commonly encountered membership groups
• The cultural, ethnic, racial and linguistic needs of Members are assessed and identified opportunities to improve provider network composition are pursued
• Strategies are implemented to recruit and retain a diverse provider network that meets the cultural needs of the membership
• Complaints, grievances, and appeals are reviewed and analyzed for issues identified by Members or other community stakeholders related to the design of activities and initiatives to meet the cultural needs of the population

WellCare makes cultural competency training available via WellCare University for all staff Members. The training program identifies methods utilized to ensure Members’ preferences, needs and values are addressed in a manner that is free from discrimination.

**Members with Complex and Special Needs**

WellCare identifies, supports and engages its most vulnerable Members at any point in their health care continuum to assist them to achieve an improved health status. WellCare provides services in a Member-centric fashion. WellCare’s objectives for serving Members with complex and special needs are but not limited to:

• Complete an annual population assessment to identify the needs of the population and subpopulations so that care management processes and resources can be updated to address Member needs. Promotion of preventive health services and the management of chronic diseases through disease management programs that encourage the use of services to decrease future morbidity and mortality in Members
• Conduct comprehensive assessments that identify Member needs and barriers to care.
• Coordinate transitions of care for Members with complex and special needs to assist navigating the complex healthcare system and accessing Provider, public and private community based resources
• Improve access to primary and specialty care ensuring that Members with complex health conditions receive appropriate services
• Consult with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers, behavioral health professionals, etc.
• Ensure that Members’ socio-economic barriers are addressed

**Utilization Management**

Utilization management (UM) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring and evaluating the utilization of healthcare services. The UM Program is a multidisciplinary, comprehensive process to manage resource utilization for optimal Member outcomes. Integral factors in the UM process include:

• Consideration of individual Member clinical needs, including those identified with special healthcare needs, cultural characteristics, safety and preferences
• An available and accessible care delivery system
• A diverse network of qualified Providers
• Clinically sound, evidence-based medical/behavioral health necessity decision-making tools to facilitate the consistent application of criteria for appropriate utilization of available resources in an efficient and effective manner
• Available and applicable plan benefits

The UM Program includes components of prior authorization as well as prospective, concurrent and retrospective review activities, each of which are designed to provide for an evaluation of health care and services based on the Member’s coverage, the appropriateness of such care and services and, to determine the extent of coverage and payment to Providers of care. WellCare does not reward its associates or Providers, physicians or other individuals or entities performing UM activities for denying coverage, services or care, and financial incentives, if any, do not encourage or promote under-utilization.

The multidisciplinary staff and practitioners employed by WellCare conduct UM activities within their legal scope of practice as identified by licensure standards.

**Chronic Care Improvement Program**

The purpose of the Chronic Care Improvement Program (CCIP) is to facilitate improvement in the quality of care and quality of life of WellCare’s medically compromised Members by coordinating care and benefits across the continuum of care, fostering adherence to a plan of care, disease education, and advocacy. The program is designed to meet the Member’s healthcare needs and improve outcomes in a cost-effective process. WellCare care management services focus on the Member as a whole to include their complex medical, behavioral health and socioeconomic needs to achieve optimal outcomes. Medicare Members usually have multiple and complex medical needs that require frequent and/or costly treatment. Population-specific chronic illnesses addressed in the WellCare CCIP include diabetes, congestive heart failure and many other conditions prevalent in the Medicare population. All Medicare Members are outreached and encouraged to participate in the Care Management Program.

The methodology to identify Members appropriate for the CCIP includes but is not limited to: review of data captured in the initial and subsequent annual HRA, referrals from Providers, discharge planners, UM, and other healthcare entities, Member self-referral and claims and encounter data mining using an internal developed algorithm.

The program utilizes evidence-based guidelines, care management assessments/re-assessments, and Member specific goals with the objective to improve Member outcomes.
Evaluation of program effectiveness includes satisfaction survey results, measurement/assessment and improvement of established performance measures and health outcomes.

When a Medicare Member enrolls with WellCare, an initial comprehensive HRA is completed within the first 90 days of enrollment to capture needed information. A secondary assessment is conducted by the care manager to gather additional needed information. The completed HRA information as well as the secondary assessment is utilized to develop the Member care plan. A plan of care is completed with the Member and shared with the PCP, specialists (if any exist), and other Members of the Interdisciplinary Care Team (ICT).

For Members actively enrolled in the CCIP, a care plan is developed and collaboratively agreed upon with the Member (when feasible) and the ICT. A follow up schedule is identified and documented. Disease-/condition-specific education materials and tools for self-management such as a weight scale or a blood pressure cuff are mailed to the Member as needed.

On follow-up calls the care manager addresses Member progress in meeting the short and long term goals established. This is documented in the medical record and any significant health status changes are shared with the ICT.

Model of Care
The Model of Care targets the population and identifies specific specialized needs so resources and services are available to those who need them. Effectiveness of the Model of Care will be evaluated through the specific measurable goals and population-specific quality indicators. Indicator data is collected on a routine and ad hoc basis, outcomes analyzed, interventions implemented for goal attainment and reports generated. Data collection follows protocols established in approved policies or program design. Data sources include administrative data such as claims, survey data, medical record documentation, or a combination of sources. There is a documented systematic step sequence for administrative data collection. Standardized tools are developed for utilization with any manual data collection such as extraction of data from medical records. Statistically valid sampling techniques are utilized as appropriate based on NCQA methodology.

WellCare has established performance outcomes for the Medicare dual eligible plans to evaluate and measure the quality of care, quality outcomes, service and access for Members. For each metric benchmarks have been established based on evidenced-based medicine found by current literature, standards and guidelines. A corrective action plan will be created and interventions identified for each indicator that fell below the desired value. The analysis, process improvement plan, implementation of interventions and improvements will be reported to the QIC for review, feedback, and approval.

Medical Records
Medical records should be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secured location. Documentation in the Member’s medical record is to be completed in a timely, legible, current, detailed and organized manner which conforms to good professional medical practice. Records should be maintained in a manner that permits effective, professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment.

Complete medical records include, but are not limited to:
- Medical charts
- Prescription files
• Hospital records
• Provider specialist reports
• Consultant and other health care professionals’ findings
• Appointment records
• Other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided

Medical records must be signed and dated.

WellCare conducts reviews of the medical records of contracted Providers to determine compliance with established documentation standards, professional practice guidelines and preventive health guidelines. In accordance with WellCare’s contract with CMS and requirements from federal and state regulatory agencies, WellCare is required to periodically assess the medical records of Members to demonstrate compliance with these requirements.

Medical record reviews are conducted to assess the quality of care delivered and documented. Medical record reviews consist of a general documentation section and an adult preventive care section. In the medical record review, the two sections are reviewed for compliance with the required elements. If a Provider does not attain a composite score of 80 percent or greater, a corrective action plan and a medical record re-evaluation is required. Information from the medical record review may be used in the re-credentialing process, as well as quality activities.

The general documentation requirements for medical records are below. Documentation requirements for adult preventive care are on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Clinical Guidelines” under “Tools” in the “Providers” drop-down menu.

All medical records, including all entries in the medical record, at a minimum must:
• Be neat, complete, clear, and timely and include all recommendations and essential findings in accordance with accepted professional practice
• Be signed and include the name and profession of the Provider
• Be legible to readers and reviewing parties
• Be dated and recorded in a timely manner
• Include the Member’s name (first and last name or identifier) on each page
• Include the following personal and biographical data in the record:
  o Name
  o Member identifier
  o Date of birth
  o Gender
  o Address
  o Home/work telephone numbers
  o Emergency contact name and telephone numbers. This may include next of kin or name of spouse
  o Legal guardianship, if applicable
  o Marital status
  o If not English, the primary language spoken by the Member and, if applicable, any translation or communication needs are addressed
• Include allergies and adverse reactions to medication
• Include a HIPAA protected health information release
• Include a current medication list
• Include a current diagnoses/problem list
• Include a summary of surgical procedures, if applicable
• Include age-appropriate lifestyle and risk counseling
• Include screening for tobacco, alcohol or drug abuse with appropriate counseling and referrals, if needed
• Include screening for domestic violence with appropriate counseling and referrals, if needed
• Include the provision of written information regarding advance directives to adults (18 years and older)
• Include an assessment of present health history and past medical history
• Include education and instructions, verbal, written, or by telephone
• Include, if surgery is proposed, a discussion with the Member of the Medical Necessity of the procedure, the risks, and alternative treatment options available
• Include evidence that results of ordered studies and tests have been reviewed
• Include consultant notes and referral reports
• Include evidence of follow-up visits, if applicable
• Include appropriate medically indicated follow-up after hospital discharge and emergency department visits

Clinical encounters/office visits must minimally include:
• Chief complaint
• History and physical examination for presenting complaint
• Treatment plan consistent with findings
• Disposition, recommendations and/or instructions provided

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to WellCare or its representatives without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request.

The Member’s medical record is the property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his or her medical record. Additional copies shall be made available to Members upon request and Providers may assess a reasonable cost.

WellCare follows State and Federal law regarding the retention of records remaining under the care, custody, and control of the physician or health care Provider. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

For more information on medical records compliance, including but not limited to, confidentiality of Member information and release of records, refer to Section 8: Compliance of this Manual.

Web Resources
WellCare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on WellCare’s website. Please check WellCare’s website frequently for the latest news and updated documents at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Quality” under “Medicare” in the “Providers” drop-down menu.
Section 4: Utilization Management, Care Management and Disease Management

Utilization Management

Overview
The Utilization Management (UM) Program defines and describes WellCare’s multidisciplinary, comprehensive approach and process to manage resource allocation. The UM Program describes the use of the Clinical Services Department’s review guidelines, WellCare’s adverse determination process, the assessment of new technology, and delegation oversight.

The UM program includes components of prior authorization, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on Member coverage, appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

WellCare does not reward its associates, practitioners, physicians, or other individuals or entities performing utilization management activities for rendering denial of coverage, services or care determinations. WellCare does not provide for financial incentives, encourage or promote under-utilization.

Medical Necessity
Medically necessary services are defined as services that include medical or allied care, goods or services furnished or ordered to:

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

Those services furnished in a hospital on an inpatient basis are ones that cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type would be considered medically necessary.

The fact that a Provider has prescribed, recommended, or approved medical or allied health goods or services does not, in itself, make such goods or services Medically Necessary or a Covered Service/benefit.

Prior Authorization
Prior authorization allows for efficient use of Covered Services and ensures that Members receive the most appropriate level of care in the most appropriate setting. Prior authorization may be obtained by the Member’s PCP or from a treating specialist or facility to which they were referred. WellCare provides a process in order to make a determination of Medical Necessity and benefits coverage for inpatient and outpatient services prior to services being rendered. Prior authorization requirements apply to pre-service decisions.
Providers may submit requests for authorization by:
- Faxing a properly completed Inpatient, Outpatient, Durable Medical Equipment (DME) and Orthotic and Prosthetic, or Home Health and Skilled Therapy Services Authorization Request Form
- Contacting WellCare via phone for inpatient notifications and urgent outpatient services
- Submitting an online authorization request via WellCare’s secure provider web portal at www.wellcare.com.

It is necessary to include the following information in the request for services:
- Member name and identification number
- The requesting Provider’s demographics
- Diagnosis code(s) and place of service
- The recommended servicing Provider’s demographics
- Medical history and any pertinent medical information related to the request, including current plan of treatment, progress notes as to the necessity, effectiveness, and goals

For the appropriate contact information, refer to the state-specific Quick Reference Guide on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

All forms are located on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Forms” under “Medicare” in the “Providers” drop-down menu.

**Prior Authorization for Members Enrolled in a Point of Service Plan**
The POS option allows Members of designated products to use Providers outside of the WellCare network for additional cost. The Member will pay more to access services outside the network except for emergency services. Authorization is required for services covered under the Member’s POS benefit. The Provider utilizing the Member’s POS benefit must inform the Member that there is a higher cost-sharing.

It is recommended that an authorization be requested for the following situations:
- Network inadequacy
- Transition of Care (TOC) period for new Members
- Continuation of Care
- If the network panel is closed

Contact UM via Provider Services for any questions pertaining to the POS option by referring to the state-specific Quick Reference Guide on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

**Notification**
Notifications are communications to WellCare with information related to a service rendered to a Member or a Member’s admission to a facility. Notification is required for a Member’s admission to a hospital. This enables WellCare to log the hospital admission and follow up with the facility on the following business day to receive clinical information. Notification can be submitted by fax, phone, or via the secure, online portal at www.wellcare.com for registered Providers. The
notification information should include Member demographics, facility name and admitting diagnosis.

**Concurrent Review**

WellCare ensures the oversight and evaluation of Members when admitted to hospitals, rehabilitation centers, and skilled nursing facilities (SNF). This oversight includes reviewing continued inpatient stays to ensure appropriate utilization of health care resources and to promote quality outcomes for Members.

WellCare provides oversight for Members receiving acute care services in facilities mentioned above to determine the initial/ongoing Medical Necessity, appropriate level of care, appropriate length of stay, and to facilitate a timely discharge.

Concurrent review is initiated as soon as WellCare is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity. The continued length of stay Authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner
- Make certain that established standards of quality care are met
- Implement timely and efficient transfer to a lower level of care when clinically indicated and appropriate
- Complete timely and effective discharge planning
- Identify referrals appropriate for DM or quality-of-care review
- Identify cases appropriate for follow up by the CM/service coordinator

Concurrent review decisions are made utilizing the following criteria:

- InterQual™
- WellCare Clinical Coverage Guidelines
- Medical Necessity
- Member benefits
- State Provider Handbooks, as appropriate
- Federal statutes and laws
- Medicare guidelines
- Hayes Health Technology Assessment

These review criteria are utilized as a guideline. Decisions will take into account the Member’s medical condition and co-morbidities. The review process is performed under the direction of the WellCare medical director.

Frequency of onsite and/or telephonic review will be based on the clinical condition of the Member. The frequency of the reviews for extension of initial determinations is based on the severity/complexity of the patient's condition, necessary treatment and discharge planning activity including possible placement in a different level of care.

The treating Provider and the facility utilization review staff will provide review information that is collected telephonically or via fax.

Clinical information is requested to support the appropriateness of the admission, continued length of stay, level of care, treatment and discharge plans.
When a hospital determines that a Member no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a Quality Improvement Organization (QIO) review. Prior to requesting a QIO review, the hospital should consult with WellCare.

**Discharge Planning**
WellCare identifies and provides the appropriate level of care as well as Medically Necessary support services for Members upon discharge from an inpatient setting. Discharge planning begins upon notification of the Member’s inpatient status to facilitate continuity of care, post-hospitalization services, referrals to a SNF or rehabilitation facility, evaluating for a lower level of care, and maximizing services in a cost-effective manner. As part of the UM process, WellCare will provide for continuity of care when transitioning Members from one level of care to another. The discharge plan will include a comprehensive evaluation of the Member’s health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional setting. This will be based on the information received from the institution and/or Provider caring for the Member.

Some of the services involved in the discharge plan include, but are not limited to:
- DME
- Transfers to an appropriate level of care, such as an inpatient nursing rehabilitation (INR) facility, long term acute care facility (LTAC) or SNF
- Home health care
- Medications
- Physical, occupational, or speech therapy (PT, OT, ST)

**Retrospective Review**
A retrospective review is any review of care or services that have already been provided.

There are two types of retrospective reviews which WellCare may perform:
- Retrospective review initiated by WellCare
  WellCare requires periodic documentation including, but not limited to, the medical record, UB and/or itemized bill to complete an audit of the Provider submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to WellCare to support accurate coding and claims submission.
- Retrospective review initiated by Providers
  WellCare will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the Member was not eligible, but became eligible with WellCare retroactively or in cases of emergency treatment and the payer is not known at the time of service. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Member’s needs at the time of service. WellCare will also identify quality issues, utilization issues and the rationale behind failure to follow WellCare’s Prior Authorization/pre-certification guidelines.

The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Member’s needs at the time of service. WellCare will also identify quality issues, utilization issues, and the rationale behind failure to follow WellCare’s prior authorization/pre-certification guidelines.
WellCare will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If WellCare is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to 14 calendar days of the post-service request.

**Referrals**
Referrals are requests by a PCP for a Member to be evaluated and/or treated by a participating specialty Provider. The PCP must document the reason for the referral and the name of the specialist in the Member’s record. The specialist must document receipt of the request for a consultation. WellCare does not require a written referral as a condition of payment for most services. No pre-communication with WellCare is necessary. If Member is using a POS benefit, the Member’s PCP should always coordinate care with out-of-network Providers and, if necessary, contact WellCare for approval. The PCP may not refuse to refer to non-network Providers, regardless of medical group or independent practice association affiliation.

**Criteria for Utilization Management Determinations**
The UM Department utilizes review criteria that are nationally recognized and based on sound scientific medical evidence. Providers with an unrestricted license, professional knowledge and/or clinical expertise in the area actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

The UM program uses numerous sources of information including, but not limited to, the following list when making coverage determinations:
- InterQual
- Medical Necessity
- Member benefits
- Federal statutes and laws
- Medicare guidelines
- Calocus
- ASAM
- Hayes Health Technology Assessment.

The nurse reviewer and/or medical director apply Medical Necessity criteria in the context of the Member’s individual circumstance and 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.

Members and Providers may request a copy of the criteria utilized for a specific determination of Medical Necessity by contacting Customer Service.

The medical review criteria stated below are updated and approved at least annually by the medical director, medical advisory committee, and QIC. Appropriate, actively practicing physicians and other Providers with current knowledge relevant to the criteria or scripts being reviewed have an opportunity to give advice or comment on development or adoption of UM criteria and on instructions for applying the criteria.

WellCare is responsible for:
- Requiring consistent application of review criteria for authorization decisions
- Consulting with the requesting Provider when appropriate
One or more of the following criteria are utilized when services are requested that require utilization review:

<table>
<thead>
<tr>
<th>Type of Criteria</th>
<th>Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage and Referral Guidelines</td>
<td>Annually</td>
</tr>
<tr>
<td>InterQual</td>
<td>Annually</td>
</tr>
<tr>
<td>Ingenix Complete Guide to Medicare Coverage Issues</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Hayes, Inc. Online™ (Medical Technology)</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Medicare Carrier and Intermediary Coverage Decisions</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Medicare National Coverage Decisions</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Federal Statutes, Laws and Regulations</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

When applying criteria to Members with more complicated conditions, WellCare will consider the following factors:

- Age
- Co-morbidities
- Complications
- Progress of treatment
- Psychological situation
- Home environment, when applicable.

WellCare will also consider characteristics of the local delivery system available for specific Members, such as:

- Availability of SNFs, sub-acute care facilities, or home care in WellCare’s service area to support the Member after hospital discharge
- Coverage of benefits for SNFs, sub-acute care facilities, or home care when needed
- Local hospitals’ ability to provide all recommended services within the estimated length of stay

When WellCare’s standard UM guidelines and criteria do not apply due to individual patient (Member) factors and the available resources of the local delivery system, the Clinical Services staff (review nurse, care manager) will conduct individual case conferences to determine the most appropriate alternative service for that Member. The medical director may also utilize his or her clinical judgment in completing the service authorization request.

All new medical technology or questionable experimental procedures will require review by the medical director prior to approval to establish guidelines where applicable.

**Organization Determinations**

For all organization determinations, Providers may contact WellCare by mail, phone, fax, or via WellCare’s website.

WellCare requires prior authorization and/or pre-certification for:

- All non-emergent and non-urgent inpatient admissions except for routine newborn deliveries
- All non-emergent or non-urgent out-of-network services (except out-of-area renal dialysis)
• Service requests identified in the Medicare authorization guidelines that are maintained within the Clinical Services Department. Refer to the state-specific Quick Reference Guide on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

For initial and continuation of services, WellCare has appropriate mechanisms to ensure consistent application of review criteria for authorization reviews, which include:

• Medical Necessity – Approved medical review criteria will be referenced and applied
• Inter-rater reliability – A process that evaluates the consistency of decisions made by licensed staff when making authorization decisions and ensures the consistent application of medical review criteria
• Consultation with the requesting Provider when appropriate

**Standard Organization Determination** – An organization determination will be made as expeditiously as the Member’s health condition requires, but no later than 14 calendar days after WellCare receives the request for service. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if WellCare justifies a need for additional information and documents how the delay is in the interest of the Member.

**Expedited Organization Determination** – A Member or any Provider may request that WellCare expedite an organization determination when the Member or his or her Provider believes that waiting for a decision under the standard timeframe could place the Member’s life, health, or ability to regain maximum function in serious jeopardy. The request will be made as expeditiously as the Member’s health condition requires, but no later than 72 hours after receiving the Member’s or Provider’s request. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if WellCare justifies a need for additional information and documents how the delay is in the interest of the Member.

WellCare’s organization determination system provides authorization numbers, effective dates for the authorization, and specifies the services being authorized. The requesting Provider will be notified verbally via telephone or fax of the authorization.

In the event of an adverse determination, WellCare will notify the Member and the Member’s representative (if appropriate) in writing and provide written notice to the Provider. Written notification to Providers will include the UM Department’s contact information to allow Providers the opportunity to discuss the adverse determination decision. The Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the Clinical Services’ UM Department. The Member may request a copy of the criteria used for a specific determination of Medical Necessity by contacting Customer Service.

**Reconsideration Requests**
WellCare provides an opportunity for the Provider to request a reconsideration of an adverse determination within seven business days of the decision. The requesting Provider will have the opportunity to discuss the decision with the clinical peer reviewer making the denial determination or with a different clinical peer if the original reviewer cannot be available within one business day of the Provider request. WellCare will respond to the request within one business day.

**Emergency Services**
Emergency Services are covered inpatient and outpatient services that are:
WellCare Health Plans
Medicare Advantage Provider Manual

Effective: February 24, 2017

WellCare is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, WellCare is not responsible for any costs such as a biopsy associated with treatment of skin lesions performed by the attending Provider who is treating a fracture.

Transition of Care
If a new Member has an existing relationship with a Provider who is not part of WellCare’s Provider network, WellCare will permit the Member to continue an ongoing course of treatment by the non-participating Provider during a transitional period.

WellCare will honor any written documentation of prior authorization of ongoing Covered Services for a period of 30 calendar days after the effective date of enrollment.

For all Members, written documentation of prior authorization of ongoing services includes the following, provided that the services were prearranged prior to enrollment with WellCare:

- Prior existing orders
- Provider appointments (e.g., dental appointments, surgeries, etc.)
- Prescriptions (including prescriptions at non-participating pharmacies)

WellCare can delay service authorization if written documentation is not available in a timely manner. Providers may contact the Claims Department for claims payment or claims resolution issues and their Provider Relations representative for rate negotiations.

Members who are inpatient at the time of disenrollment from WellCare will be covered by WellCare throughout the acute inpatient stay, however, WellCare will not be responsible for any discharge needs the Member may have.

WellCare will take immediate action to address any identified urgent medical needs.

Continued Care with a Terminated Provider
When a Provider terminates or is terminated without cause, WellCare will allow Members in active treatment to continue either through the completion of their condition (up to 90 calendar days) or until the Member selects a new Provider.

- Furnished by a Provider qualified to furnish emergency services
- Needed to evaluate or stabilize an emergency medical condition

It is WellCare’s policy that emergency services are covered:

- Regardless of whether services are obtained within or outside the network of Providers available
- Regardless of whether there is prior authorization for the services. In addition:
  - No materials furnished to Members (including wallet card instructions) may contain instructions to seek prior authorization for emergency services, and Members must be informed of their right to call 911
  - No materials furnished to Providers, including contracts, may contain instructions to Providers to seek prior authorization before the Member has been stabilized
- In accordance with a prudent layperson’s definition of “emergency medical condition” regardless of the final medical diagnosis
- Whenever a WellCare Provider or other WellCare representative instructs a Member to seek emergency services within or outside the Member’s WellCare plan coverage
WellCare will inform the Provider that care provided after termination shall continue under the same terms, conditions and payment arrangements as in the terminated contract.

If an obstetrical Provider terminates without cause and requests an approval for treatment for a pregnant Member who is in treatment, the Member will be permitted to continue care until the Member’s post-partum visit is completed.

If a Provider is terminated for cause, WellCare will direct the Member immediately to another participating Provider for continued services and treatment.

**Transition of Care**

To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Health Plan for the transition of Members to other Participating Providers. The terms and conditions of this Agreement shall apply to any such post expiration or termination activities, provided that if a Provider is capitated, Health Plan shall pay the Provider for such Covered Services at 100 percent of Health Plan’s then current rate schedule for the applicable Benefit Plans. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

**Continuity of Care**

WellCare maintains and monitors a panel of PCPs from which the Member may select a personal PCP. All Members may select and/or change their PCP to another participating WellCare Medicare PCP without interference. WellCare requires Members to obtain a referral before receiving specialist services and has a mechanism for assigning PCPs to Members who do not select one. WellCare will also:

- Provide or arrange for necessary specialist care and, in particular, give female Members the option of direct access to a women’s health specialist within the network for women’s routine and preventive health care services. WellCare will arrange for specialty care outside of WellCare’s Provider network when network Providers are unavailable or inadequate to meet a Member’s medical needs
- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all Members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. WellCare utilizes the provision of translator services and interpreter services
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies, and utilization management that allow for individual Medical Necessity determinations
- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services
- Have in effect procedures that:
  - Establish and implement a treatment plan that is appropriate
  - Include an adequate number of direct access visits to specialists
  - Are time-specific and updated periodically
  - Facilitate coordination among Providers
  - Considers the Member’s input
Second Opinion
Members have the right to a second surgical/medical opinion in any instance when the Member disagrees with his or her Provider’s opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness. The second surgical/medical opinion, if requested, is to come from a Provider chosen by the Member who may select:

- A Provider that is participating with WellCare
- A non-participating Provider located in the same geographical service area of WellCare, if a participating Provider is not available

If WellCare’s network is unable to provide necessary services to a particular Member, WellCare will adequately and timely cover these services out-of-network for the Member for as long as WellCare is unable to provide them. WellCare will be financially responsible for a second surgical/medical opinion.

Members must inform their PCP of their desire for a second surgical/medical opinion. If a participating WellCare Provider is selected, the PCP will issue a referral to the Member for the visit. If a non-participating Provider is required, the PCP will contact WellCare for authorization.

Any tests that are deemed necessary as a result of the second surgical/medical opinion will be conducted by participating WellCare Providers. The PCP will review the second surgical/medical opinion and develop a treatment plan for the Member. If the PCP disagrees with the second surgical/medical opinion request for services, the PCP must still submit the request for services to WellCare for an organization determination on the recommendation.

The Member may file an appeal if WellCare denies the second surgical/medical opinion Provider’s request for services. The Member may file a grievance if the Member wishes to follow the recommendation of the second opinion Provider and the PCP does not forward the request for services to WellCare.

Medicare Quality Improvement Organization Review Process
WellCare will ensure Members receive written notification of termination of service from Providers no later than two calendar days before the proposed end of service for SNFs, Home Health Agencies (HHAs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs). The standard Notice of Medicare Non-Coverage letter required by CMS will be issued. This letter includes the date coverage of service ends and the process to request an expedited appeal with the appropriate QIO. Upon notification by the QIO that a Member has requested an appeal, WellCare will issue a Detailed Explanation of Non-Coverage which indicates why services are either no longer reasonable or necessary or are no longer covered.

The standardized Notice of Medicare Non-Coverage of SNF, HHA and CORF services will be given to the Member or, if appropriate, to the Member’s representative, by the Provider of service no later than two calendar days before the proposed end of services. If the Member’s services are expected to be fewer than two calendar days in duration, the Provider should notify the Member or, if appropriate, the Member’s representative, at time of admission. If the services will be rendered in a non-institutional setting and the span of time between the services exceeds two calendar days, the notice should be given no later than two services prior to termination of the service.
WellCare is financially liable for continued services until two calendar days after the Member receives valid notice. A Member may waive continuation of services if she or he agrees with being discharged sooner than two calendar days after receiving the notice.

Members who desire a fast-track appeal must submit a request for appeal to the QIO, in writing or by telephone, by noon of the first day after the day of delivery of the termination notice or, where a Member receives the Notice of Medicare Non-Coverage more than two calendar days prior to the date coverage is expected to end, by noon of the day before coverage ends. Upon notification by the QIO that a Member has requested an appeal, WellCare will issue a Detailed Explanation of Non-Coverage which indicates why services are either no longer reasonable or necessary or are no longer covered.

Coverage of Provider services continues until the date and time designated on the termination notice, unless the Member appeals and the QIO reverses WellCare’s decision.

A Member who fails to request an immediate fast-track QIO review in accordance with these requirements may still file a request for an expedited reconsideration with WellCare.

**Required Notification to Members for Observation Services**
In compliance with the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE ACT) effective August 6, 2015, contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any Member who receives observation services as an outpatient for more than 24 hours. The MOON is a standardized notice to a Member informing that the Member is an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status. The MOON must be delivered no later than 36 hours after observation services are initiated, or if sooner upon release.

The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions can be found at [www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html)

**Notification of Hospital Discharge Appeal Rights**
Prior to discharging a Member or lowering the level of care within a hospital setting, WellCare will secure concurrence from the Provider responsible for the Member’s inpatient care.

WellCare will ensure Members receive a valid written notification of termination of inpatient services from the facility according to the guidelines set by Medicare. Hospitals must issue the Important Message within two calendar days of admission, obtain signature of the patient or the signature of their authorized representative, and provide a signed follow-up copy to the patient as far in advance of discharge as possible, but not more than two calendar days before discharge. This letter will include the process to request an immediate review with the appropriate QIO.

Members who desire an immediate review must submit a request to the QIO, in writing or by telephone, by midnight of the day of discharge. The request must be submitted before the Member leaves the hospital.

If the Member fails to make a timely request to the QIO she or he may request an expedited reconsideration by WellCare.
Upon notification by the QIO that a Member has requested an immediate review, WellCare will contact the facility, request all relevant medical records, a copy of the executed IM, and evaluate for validity. If after review, WellCare concurs that the discharge is warranted, WellCare will issue a Detailed Notice of Discharge providing a detailed reason why services are either no longer reasonable, necessary or are no longer covered.

Coverage of inpatient services continues until the date and time designated on the Detailed Notice of Discharge, unless the Member requests an immediate QIO review. Liability for further inpatient hospital services depends on the QIO decision.

If the QIO determines that the Member did not receive valid notice, coverage of inpatient services by WellCare continues until at least two calendar days after valid notice has been received. Continuation of coverage is not required if the QIO determines that the coverage could pose a threat to the Member’s health or safety.

The burden of proof lies with WellCare to demonstrate that discharge is the correct decision, either on the basis of Medical Necessity, or based on other Medicare coverage policies. To meet this burden, WellCare must supply any and all information that the QIO requires to sustain WellCare’s decision.

WellCare is financially responsible for coverage of services, regardless of whether it has delegated responsibility for authorizing coverage or termination decisions to its Providers.

If the QIO reverses WellCare’s termination decision, WellCare must provide the Member with a new notice when the hospital or WellCare once again determines that the Member no longer requires acute inpatient hospital care.

**Availability of Utilization Management Staff**

WellCare’s Clinical 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 per day, seven days per week, including holidays.

For more information on contacting the Clinical Services Department via Provider Services, refer to the state-specific Quick Reference Guide on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

**Care Management Program**

**Overview**

WellCare offers comprehensive care management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. WellCare trusts Providers will help coordinate the placement and cost-effective treatment of patients who are eligible for WellCare’s Care Management Programs. For specific information on Care Management programs for dual-eligible Members, or Model of Care, see Section 10: Dual-Eligible Members in this Manual.

WellCare’s Care Management teams are led by specially trained registered nurse and licensed clinical social worker care managers who assess the Member’s risk factors, 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.

WellCare’s Care Management teams also serve in a support capacity to the PCP and assist in actively linking the Member to Providers, medical services, residential, social and other support services, as needed. Providers may request care management services for any Member.

The care management process begins with Member identification, and follows the Member until discharge from the Program. Members may be identified for care management in various ways, including:

- A referral from a Member’s PCP
- Self-referral
- Referral from a family member
- After completing a health risk assessment
- Data mining for Members with high utilization

WellCare’s philosophy is that the Care Management Program is an integral management tool in providing a continuum of care for Members. Key elements of the care management process include:

- **Clinical Assessment and Evaluation** – A comprehensive assessment of the Member is completed to determine where she or he 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 as well as the PCP to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the Provider’s plan of care
- **Service Facilitation and Coordination** – Working with community resources to facilitate Member adherence with the plan of care. Activities may be as simple as reviewing the plan with the Member and/or caregiver or as complex as arranging services, transportation and follow-up
- **Member Advocacy** – Advocating on behalf of the Member within the complex labyrinth of the health care system. Care managers assist Members with seeking the services to optimize their health. Care management emphasizes continuity of care for Members through the coordination of care among physicians and other Providers

Members commonly identified for WellCare’s Care Management Program include:

- **Catastrophic Injuries** – Such as head injury, near drowning, burns
- **Multiple Chronic Conditions** – Multiple co-morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple barriers to quality health care (i.e., Acquired Immune Deficiency Syndrome (AIDS))
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up
- **Complex Discharge Needs** - Members discharged home from acute inpatient or SNF with multiple service and coordination needs (i.e., DME, PT/OT, home health) complicated, non-healing wounds, advanced illness, etc.

Care managers work closely with the Provider regarding when to discharge the Member from the Care Management Program. A Member may be discharged from the Care Management Program if he or she:
• Is meeting primary care plan goals
• Declined additional care management services
• Disenrolled from WellCare
• Is unable to be contacted by WellCare

Provider Access to Care Management
Refer to Access to Care and Disease Management Programs in the Disease Management section below.

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 educating the Member about the particular disease and self-management techniques, monitoring the Member for adherence to the treatment plan and consistently using validated, industry-recognized evidence-based Clinical Practice Guidelines by the treatment team and the disease manager.

The DM Program includes the following conditions:
• Asthma - adult and pediatric
• Coronary Artery Disease (CAD)
• Congestive Heart Failure (CHF)
• COPD
• Diabetes - adult and pediatric
• Hypertension (HTN)

Additional programs available include obesity and smoking cessation.

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

Interventions for Members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized Clinical Practice Guidelines. Members identified at the highest stratification levels receive a comprehensive assessment by a 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 Clinical Practice Guidelines adopted by WellCare are on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Clinical Guidelines” under “Tools” in the “Providers” drop-down menu.

Access to Care and Disease Management Programs
WellCare’s Transition Needs Assessment (TNA) Program assists new Members in their transition from Medicare or another managed care organization to WellCare. The program involves outreach to these Members prior to their effective date, and within the first 30 days, of their enrollment. During this outreach, Members are gauged for their health care needs including, but not limited to, their primary and specialist Providers, current prescriptions, DME and home health. Members are also screened for eligibility for WellCare’s Care Management and Disease Management Programs, and any additional behavioral health care needs.
If a Provider would like to refer an established Member as a potential candidate to WellCare’s Care Management Programs or would like more information, they may call the care management referral line. For more information on the care management referral line, refer to the state-specific *Quick Reference Guides* on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.
Section 5: Claims

Overview
The focus of the Claims Department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for Providers to access a representative in the Customer Service Department. For more information on claims submission, refer to the state-specific Quick Reference Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

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

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

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts. Providers will no longer receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from PaySpan’s website, once registration is completed.

Providers can register using PaySpan’s enhanced Provider registration process at payspan.com. 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
Unless otherwise stated in the Agreement, Providers must submit Clean Claims (initial, corrected and voided) to WellCare within 180 calendar days from the date of discharge for inpatient services or the date of service for all other services. 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 CMS, WellCare may deny payment of any claim that fails to meet WellCare’s submission requirements for Clean Claims or failure to timely submit a Clean Claim to WellCare.

Please note that claims filed by Providers who are not part of the network must be filed no later than 12 months, or one calendar year, after the date the services were furnished.

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

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by WellCare
• A Provider’s electronic submission sheet that contains 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
  o WellCare’s product name or line of business

The following items are examples of what is not acceptable as evidence of timely submission:
• Strategic National Implementation Process (SNIP) Rejection Letter
• A copy of the Provider’s billing screen

Tax ID and National Provider Identifier Requirements
WellCare requires the payer-issued Tax Identification Number (Tax ID / TIN) and National Provider Identifier (NPI) on all claims submissions, with the exception of atypical Providers. Atypical Providers must pre-register with WellCare before submitting claims to avoid NPI rejections. WellCare will reject claims without the Tax ID and NPI. More information on NPI requirements, including the Health Insurance Portability and Accountability Act of 1996’s (HIPAA) NPI Final Rule Administrative Simplification, is available on the CMS website at www.cms.gov/Regulations-and-Guidance/HIPPA-Administrative-Simplification/NationalProviderStand

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

Preauthorization number
If a preauthorization number was obtained, the Provider must include this number in the appropriate data field on the claim.

National Drug Codes
WellCare follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit National Drug Codes as required by CMS.

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

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

Claims Submission Requirements
Providers using electronic submission shall submit Clean Claims to WellCare or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS 1500/ UB-04 (or their successors), as applicable. 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 or compensation is due for a Covered Service, and 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 or Non-Covered Services. For more information on paper submission of claims and WellCare’s Covered Services, refer to the state-specific *Quick Reference Guides* on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

**Electronic Claims Submissions**
WellCare accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to WellCare must be in the ANSI ASC X12N format, version 5010A, or its successor. For more information on EDI implementation with WellCare, refer to WellCare’s *Companion Guides* on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Claims” under “Medicare” in the “Providers” drop-down menu.

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or the clearinghouses WellCare uses to establish EDI with WellCare. For a list of clearinghouses WellCare uses, for information on the WellCare’s unique payer identification numbers used to identify WellCare on electronic claims submissions, or to contact WellCare’s EDI team, refer to the *Provider Resource Guide* on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

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

To promote consistency and efficiency for all claims and encounter submissions to WellCare, it is WellCare’s policy that these requirements apply to all paper and DDE transactions.

**Paper Claims Submissions**
Providers are encouraged to submit claims to WellCare electronically. Claims not submitted electronically may be subject to penalties as specified in the Agreement. For assistance in creating an EDI process, contact WellCare’s EDI team by referring to the state-specific *Quick Reference Guides* on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

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

- All paper claims must 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:
  - The information must be aligned within the data fields and must be:
    - On an original red-ink-on-white paper claim form
    - Typed. Do not print, hand-write, or stamp any extraneous data on the form
WellCare may choose to review claims if data analysis deems it appropriate. WellCare may review hospital admissions on a specific Member if it appears that two or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the Provider) WellCare will apply its readmission policy and make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. WellCare may recoup overpayments from Providers who do not submit the requested medical records or who do not remit the overpayment amounts identified by WellCare.

Pre-Admission Services Payment Policy
WellCare will not reimburse outpatient services provided within the three days prior to an inpatient admission (including but not limited to: outpatient services followed by admission before midnight of the following day, preadmission diagnostic services, and other preadmission services). WellCare will apply this policy regardless of the status of the outpatient provider/facility, and includes but not limited to preadmission services performed by an outpatient provider/facility who (i) is the same as the inpatient provider/facility; (ii) is an affiliate of the inpatient provider/facility; (iii) bills under the same tax identification number as the inpatient provider/facility; (iv) is part of the same hospital system/facility as the inpatient provider; or (v) is owned by the same corporate parent as the inpatient provider/facility.

Disclosure of Coding Edits
WellCare uses claims editing software programs to assist in determining proper coding for Provider claims payment. 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. They may also result in adjustments to the Provider’s claims payment or a request for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to WellCare. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a Non-Covered Service.
Prompt Payment
WellCare will pay Clean Claims in accordance with the terms of the Agreement.

Rate Updates
WellCare implements and prospectively applies changes to its fee schedules and CMS’s changes to Medicare fee schedules as of the later of:

- The effective date of the change
- 45 days from the date CMS publishes the change on its website

WellCare will not retrospectively apply increases or decreases in rates to claims that have already been paid.

Coordination of Benefits (COB)
WellCare shall coordinate payment for Covered Services in accordance with the terms of a Member’s benefit plan, applicable state and federal laws, and CMS guidance. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary. COB information can be submitted to WellCare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the EOB. WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws.

Members under the Medicare line of business may be covered under more than one insurance policy at a time. In the event:

- A claim is submitted for payment consideration secondary to primary insurance carrier, other primary insurance information, such as the primary carrier’s EOB, must be provided with the claim. WellCare has the capability of receiving EOB information electronically. To submit other insurance information electronically, refer to the WellCare Companion Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Claims” under “Medicare” in the “Providers” drop-down menu
- WellCare has information on file to suggest the Member has other insurance, WellCare may deny the claim
- The primary insurance has terminated, the Provider is responsible for submitting the initial claim with proof that coverage was terminated. In the event a claim was denied for other coverage, the Provider must resubmit the claim with proof that coverage was terminated
- Benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds WellCare’s liability, no additional payment will be made

The Order of Benefit Determination grid below for MA Members outlines when WellCare would be the primary or secondary payer:
## Order of Benefit Determination

<table>
<thead>
<tr>
<th>Member</th>
<th>Condition</th>
<th>Pays First (Primary)</th>
<th>Pays Second (Secondary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 65 or older and covered by a group health plan because of work or covered under a working spouse of any age</td>
<td>Employer has 20 or more employees</td>
<td>Other Coverage</td>
<td>WellCare</td>
</tr>
<tr>
<td>Age 65 or older and covered by a group health plan because of work or covered under a working spouse of any age</td>
<td>Employer has less than 20 employees</td>
<td>WellCare</td>
<td>Other Coverage</td>
</tr>
<tr>
<td>Age 65 or older and covered by a group Health Plan after retirement</td>
<td>Has Medicare Coverage</td>
<td>WellCare</td>
<td>Other Coverage</td>
</tr>
<tr>
<td>Disabled and covered by a large group health plan from work or from a family Member working</td>
<td>Employer has 100 or more employees</td>
<td>Other Coverage</td>
<td>WellCare</td>
</tr>
<tr>
<td>Has end-stage renal disease (ESRD) and group health plan coverage (including a retirement plan)</td>
<td>First 30 months of eligibility or entitlement to Medicare</td>
<td>Other Coverage</td>
<td>WellCare</td>
</tr>
<tr>
<td>Has end-stage renal disease (ESRD) and group health plan coverage (including a retirement plan)</td>
<td>After 30 months</td>
<td>WellCare</td>
<td>Other Coverage</td>
</tr>
<tr>
<td>Has end-stage renal disease (ESRD) and group health plan coverage and COBRA coverage</td>
<td>First 30 months of eligibility or entitlement to Medicare</td>
<td>Other Coverage</td>
<td>WellCare</td>
</tr>
<tr>
<td>In an accident where no-fault or liability insurance is involved</td>
<td>Entitled to Medicare</td>
<td>Other Coverage</td>
<td>WellCare</td>
</tr>
<tr>
<td>Workers’ compensation/ Job related illness or injury</td>
<td>Entitled to Medicare</td>
<td>Other Coverage</td>
<td>Non-Covered Medicare service</td>
</tr>
<tr>
<td>Veteran with Veteran benefits</td>
<td>Entitled to Medicare</td>
<td>Other Coverage</td>
<td>Non-Covered Medicare service</td>
</tr>
<tr>
<td>Covered under TRICARE</td>
<td>Service from a military hospital or other federal Provider</td>
<td>Other Coverage</td>
<td>Non-Covered Medicare service</td>
</tr>
<tr>
<td>Covered under TRICARE</td>
<td>Covered Medicare services not provided by a military hospital or federal Provider</td>
<td>WellCare</td>
<td>Other Coverage</td>
</tr>
</tbody>
</table>
## Encounters Data

### Overview
This section is intended to give Providers necessary information to allow them to submit encounter data to WellCare. If encounter data do not meet the requirements set forth in WellCare’s government contracts for timeliness of submission, completeness or accuracy, federal and state agencies (e.g., CMS) have the ability to impose significant financial sanctions on WellCare. WellCare requires all delegated vendors, delegated Providers, and capitated Providers to submit encounter data to WellCare, even if they are reimbursed through a capitated arrangement.

### Timely and Complete Encounters Submission
Unless otherwise stated in the Agreement, vendors and Providers should submit complete and accurate encounter files to WellCare as follows:
- On a weekly basis
- Capitated entities will submit within 10 calendar days of service date
- Non-capitated entities will submit within 10 calendar days of the paid date

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

### Accurate Encounters Submission
All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines per the federal requirements. SNIP levels 1 through 5 shall be maintained. Once WellCare receives a Provider’s encounters, the encounters are loaded into WellCare’s encounters system and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on Workgroup for Electronic Data Interchange (WEDI) SNIP Edits, refer to the Transaction Compliance and Certification white paper at [www.wedi.org](http://www.wedi.org). For more information on submitting encounters electronically, refer to the Companion Guides on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Claims” under “Medicare” in the “Providers” drop-down menu.

Vendors are required to comply with any additional encounters validations as defined by CMS.

### Encounters Submission Methods
Delegated Providers may submit encounters using several methods: electronically, through WellCare’s contracted clearinghouse(s), via DDE or using WellCare’s Secure File Transfer Protocol (SFTP) process.

<table>
<thead>
<tr>
<th>Member</th>
<th>Condition</th>
<th>Pays First (Primary)</th>
<th>Pays Second (Secondary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black lung disease and covered under the Federal Black Lung Program</td>
<td>Entitled to Medicare and Federal Black Lung Program</td>
<td>Other Coverage</td>
<td>WellCare</td>
</tr>
<tr>
<td>Age 65 or over or disabled and covered by Medicare and COBRA</td>
<td>Entitled to Medicare</td>
<td>WellCare</td>
<td>Other Coverage</td>
</tr>
</tbody>
</table>
Submitting Encounters Using SFTP Process (*Preferred Method*)
WellCare accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using WellCare’s SFTP and process. Refer to WellCare’s ANSI ASC X12 837I, 837P, and 837D Health Care Claim / Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. For more information on EDI implementation with WellCare, refer to WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Claims” under “Medicare” in the “Providers” drop-down menu.

Submitting Encounters Using DDE
Delegated vendors and Providers may submit their encounter information directly to WellCare using the DDE portal. The DDE tool can be found on the secure, online Provider Portal at [www.wellcare.com](http://www.wellcare.com). For more information on free DDE options, refer to the state-specific *Provider Resource Guide* on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

Encounters Data Types
There are four encounter types for which delegated vendors and Providers are required to submit encounter records to WellCare. Encounter records should be submitted using the HIPAA-standard transactions for the appropriate service type. The four encounter types are:

- Dental – 837D format
- Professional – 837P format
- Institutional – 837I format
- Pharmacy – NCPDP format

This Manual is intended to be used in conjunction with WellCare’s ANSI ASC X12 837I, 837P, and 837D health care claim / encounter institutional, professional, and dental guides.

Encounters submitted to WellCare from a delegated Provider can be a new, voided or replaced / overlaid encounter. The definitions of the types of encounters are as follows:

- New Encounter – An encounter that has never been submitted to WellCare previously
- Voided Encounter – An encounter that WellCare deletes from the encounter file and is not submitted to the state
- Replaced or Overlaid Encounter – An encounter that is updated or corrected within the system

Balance Billing
Providers shall accept payment from WellCare for Covered Services provided to WellCare Members in accordance with the reimbursement terms outlined in the Agreement. Payment from WellCare constitutes payment in full, with the exception of applicable co-payments. For Covered Services, Providers shall not balance bill Members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of WellCare’s claims policies and/or procedures does not indicate that the service provided is a Non-Covered Service, and Members are to be held harmless for Covered Services.

Providers may not bill Members for:

- The difference between actual charges and the contracted reimbursement amount
- Services denied due to timely filing requirements
- Covered services for which a claim has been returned and denied for lack of information
- Remaining or denied charges for those services where the Provider fails to notify WellCare of a service that required Prior Authorization
- Covered services that were not Medically Necessary, in the judgment of WellCare, unless prior to rendering the service the Provider obtains the Member’s informed written consent and the Member receives information that he or she will be financially responsible for the specific services

**Member Expenses and Maximum Out-of-Pocket**
The Provider is responsible for collecting Member expenses. Providers are not to bill Members for missed appointments, administrative fees or other similar type fees. If a Provider collects Member expenses determined to exceed the Member’s responsibility, the Provider must reimburse the Member the excess amount. The Provider may determine an excess amount by referring to the Explanation of Payment (EOP).

For certain benefit plans, Member expenses are limited by a maximum out-of-pocket amount. For more information on maximum out of pocket amounts, and responsibilities of a Provider of care to a Medicare Member, refer to Section 2: Provider and Member Administrative Guidelines.

**Provider-Preventable Conditions**
WellCare follows CMS guidelines regarding Hospital Acquired Conditions, Never Events, and other Provider-Preventable Conditions (collectively, PPCs). Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:
- A different procedure altogether
- The correct procedure but on the wrong body part
- 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](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html) and include such events as an air embolism, falls, and catheter-associated urinary tract infection.

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

**Reopening and Revising Determinations**
A reopening request must be made in writing, clearly stating the specific reason for requesting the reopening. It is the responsibility of the Provider to submit the requested documentation within 90 days of the denial to re-open the case.

All decisions to grant reopening are at the discretion of WellCare. See the Medicare Claims Processing Manual, Chapter 34, for Reopening and Revision of Claim Determinations and Decisions guidelines.

**Disputed Claims**
The claims payment 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 WellCare in writing within 90 calendar days of the date of denial of the EOP for participating Providers and within 120 days of the date of denial of the EOP for non-participating Providers.

Please provide the following information on the written Provider dispute:

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

To initiate the process, please refer to the state-specific Quick Reference Guides located on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

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

How to submit a corrected or voided claim electronically:

- Loop 2300 Segment CLM composite element CLM05-3 should be ‘7’ or ‘8’ – indicating to replace ‘7’ or void ‘8’
- Loop 2300 Segment REF element REF01 should be ‘F8’ indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be ‘the original claim number’ - the control number assigned to the original bill (original claim reference number for the claim you 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 WellCare’s original claim number and bill the frequency code per industry standards.

Example:

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

```
<table>
<thead>
<tr>
<th>4 - TYPE OF BILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>117 - NON-REBATE</td>
</tr>
</tbody>
</table>
```

**Box 64 – Place the claim number of the prior claim in Box 64**

```
<table>
<thead>
<tr>
<th>64 DOCUMENT Control NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>298170064</td>
</tr>
</tbody>
</table>
```
For Professional claims, Provider must include WellCare’s original claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

<table>
<thead>
<tr>
<th>22. RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 or 8</td>
<td>1234567890</td>
</tr>
</tbody>
</table>

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

Please note: If “corrected claim” is handwritten, stamped or typed on the claim form without the appropriate Frequency Code “7” or “8” along with the original reference number as indicated above, the claim will be considered an original first-time claim submission.

The correction or void process involves two transactions:

1. The original claim will be negated – paid or zero payment (zero net amount due to a co-payment, coinsurance or deductible) – and noted “Payment lost/voided/missed.” This process will deduct the payment for this claim, or zero net amount if applicable.
2. The corrected or voided claim will be processed with the newly submitted information and noted “Adjusted per corrected bill.” This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

The payment reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

Reimbursement
WellCare applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes based on the place of treatment (physician office services versus other places of treatment).

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

- **Incidental Surgeries/Complications** - A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by WellCare’s medical director regarding 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 Providers should not submit a claim for such visits and Providers are not compensated separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- **Multiple Procedures** - Payment for multiple procedures is based on current CMS percentages methodologies. 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.

- **Assistant Surgeon** - Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies. WellCare uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes”, CMS is used as the secondary source.

- **Co-Surgeon** - Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his or her distinct, operative work, by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier ‘62’ added.

**Modifiers**

WellCare follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

**Allied Health Providers**

WellCare follows CMS reimbursement guidelines regarding Allied Health Professionals.

**Medicare Overpayment Recovery**

WellCare strives for 100 percent payment quality but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as retroactive Member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s) and other reasons.

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will follow the same methodology used by the CMS Recovery Audit Contractor (RAC) program by limiting its recovery to three years from the last payment date. However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, required by, or initiated at the request of, a self-insured plan, or required by a state or federal government program or coverage that is provided by a state or a municipality thereof to its respective employees, retirees or Members.

In all cases, WellCare, or its designee, will provide a written notice to the Provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Member. The notice will also provide the carrier address WellCare has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 45 calendar days for the Provider to send in the refund, request further information or dispute the overpayment. For more information on the CMS RAC, refer to the CMS website at [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/index.html).

Failure of the Provider to respond within the above timeframes will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an
Explanation of Payment (EOP) indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months, the Provider may be contacted by WellCare, or its designee, to arrange payment.

If the Provider independently identifies an overpayment, it can send a corrected claim (refer to the corrected claim section of the Manual); contact Provider Services to arrange an off-set against future payments; or send a refund and explanation of the overpayment to:

WellCare Health Plans, Inc.
Recovery Department
PO Box 31584
Tampa, FL 33631-3584

For more information on contacting Provider Services, refer to the state-specific *Quick Reference Guides* which may be found on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

**Benefits During Disaster and Catastrophic Events**

In the event of a presidential emergency declaration, a presidential (major) disaster declaration, a declaration of emergency or disaster by a governor, or an announcement of a public health emergency by the secretary of health and human services – but absent an 1135 waiver by the Secretary – WellCare will:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A/B benefits must, per 42 CFR 422.204(b)(3), be furnished at Medicare-certified facilities)
- Waive in full, requirements for authorization or pre-notification
- Temporarily reduce WellCare-approved out-of-network cost sharing to in-network cost sharing amounts
- Waive the 30-calendar-day notification requirement to Members as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the Member

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency timeframe has not been closed 30 calendar days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, WellCare should resume normal operations 30 calendar days from the initial declaration.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>An institutional claim</td>
<td><em>Condition Code</em> will be DR or Modifier CR</td>
</tr>
<tr>
<td>A professional claim</td>
<td><em>Modifier</em> will be CR Code</td>
</tr>
</tbody>
</table>
Section 6: Credentialing

Overview
Credentialing is the process by which the appropriate WellCare peer review bodies evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. 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.

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 health care
- Accreditation status, as applicable to non-individuals

Practitioners are required to be credentialed prior to being listed as a WellCare-participating network Provider of care or services to its Members.

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

Please take note of the following credentialing process highlights:
- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation, and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank
- Physicians, allied health professionals, and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network Providers of services to WellCare Members
- Satisfactory site inspection evaluations are required to be performed in accordance with state and federal accreditation requirements
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider

Credentialing may be done directly by WellCare or by an entity approved by WellCare for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall be required to meet WellCare’s criteria to ensure that the credentialing capabilities
of the delegated entity clearly meet federal and state accreditation (as applicable) and WellCare requirements.

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

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

**Practitioner’s Right to Be Informed of Credentialing/Re-Credentialing Application Status**
Written requests for information may be emailed to credentialinginquiries@wellcare.com. Upon receipt of a written request, WellCare will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared with the information provided by the practitioner.

**Practitioner’s Right to Review Information Submitted in Support of Credentialing/ Re-Credentialing Application**
The practitioner may review documentation submitted by him 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 WellCare restrictions. WellCare, or its designee, will review the corrected information and explanation at the time of considering the practitioner’s credentials for Provider network participation or re-credentialing.

The Provider may not review peer review information obtained by WellCare.

**Right to Correct Erroneous Information and Receive Notification of the Process and Timeframe**
In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by WellCare, the practitioner has the right to review the information that was submitted in support of his or her application, and has the right to correct the erroneous information. WellCare will provide written notification to the practitioner of the discrepant information.

WellCare’s written notification to the practitioner will include:
- The nature of the discrepant information
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections
- The timeframe for submitting the corrections
- The addressee in the Credentialing Department to whom corrections must be sent
- WellCare’s documentation process for receiving the correction information from the Provider
- WellCare’s review process

**Baseline Criteria**
Baseline criteria for practitioners to qualify for Provider network participation:
License to Practice – Practitioners must have a current, valid, unrestricted license to practice.

Drug Enforcement Administration Certificate – Practitioners must have a current valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for M.D., D.O., D.P.M., D.D.S., D.M.D.).

Work History – Practitioners must provide a minimum of five years’ relevant work history as a health professional.

Board Certification – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a Provider for WellCare, or must have verifiable educational/training from an accredited training program in the specialty requested.

Hospital-Admitting Privileges – Specialist practitioners shall have hospital-admitting privileges at a WellCare-participating hospital (as applicable to specialty). PCP’s may have hospital-admitting privileges or may enter into a formal agreement with another WellCare-participating Provider who has admitting privileges at a WellCare-participating hospital, for the admission of Members.

Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare plan. Existing Providers who are sanctioned, and thereby restricted from participation in any government program, are subject to immediate termination in accordance with WellCare policy and procedure and the Agreement.

Providers who Opt-Out of Medicare – A Provider who opts out of Medicare is not eligible to become a participating Provider. An existing Provider who opts out of Medicare is not eligible to remain as a participating Provider for WellCare. At the time of initial credentialing, WellCare reviews the state-specific opt-out listing maintained on the designated state carrier’s website to determine whether a Provider has opted out of Medicare. The opt-out website is monitored on an ongoing/quarterly basis by WellCare.

Liability Insurance
WellCare Providers (all disciplines) are required to carry and continue to maintain professional liability insurance, unless otherwise agreed by WellCare in writing.

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

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

- Office-site criteria
- Physical accessibility
- Physical appearance
- Adequacy of waiting room and examination room space
- Medical / treatment record keeping criteria
SIEs are conducted for:
- Unaccredited facilities
- State-specific initial credentialing requirements
- State-specific re-credentialing requirements
- When complaint is received relative to office site criteria

In those states where initial SIEs are not a requirement for credentialing, there is ongoing monitoring of Member complaints. SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

**Covering Physicians**
Primary care physicians in solo practice must have a covering physician who also participates with, or is credentialed with, WellCare.

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

Dependent AHPs include the following, and are required to provide collaborative practice information to WellCare:
- ARNPs
- Certified nurse midwives (CNM)
- PAs
- Osteopathic Assistants (OA)

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

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

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

**Updated Documentation**
In accordance with the Agreement, Providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to Provider type) to WellCare, prior to or concurrent with expiration.
**Office of Inspector General Medicare/Medicaid Sanctions Report**

On a monthly basis, WellCare or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against WellCare’s network of Providers. If participating Providers are identified as being currently sanctioned, such Providers are subject to immediate termination, in accordance with WellCare policies and procedures and the Agreement.

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

On a monthly basis, WellCare, or its designee, contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of WellCare Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and WellCare policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the Provider requesting a full explanation, which is then reviewed by the Credentialing/peer review committee. The committee makes a determination as to whether the Provider should continue participation or whether termination should be initiated.

**Participating Provider Appeal through the Dispute Resolution Peer Review Process**

WellCare may immediately suspend, pending investigation, the participation status of a Provider who, in the sole opinion of WellCare’s medical director, is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of Members.

WellCare has a Participating Provider dispute resolution peer review panel process in the event WellCare chooses to alter the conditions of participation of a Provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider dispute resolution peer review process has two levels. All disputes in connection with the actions listed below are referred to a first level peer review panel consisting of at least three qualified individuals of whom at least one is a participating Provider and a clinical peer of the practitioner that filed the dispute.

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

The following actions by WellCare entitle the practitioner affected to the provider dispute resolution peer review panel process:

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

Notification of the adverse recommendation, together with reasons for the action, the practitioner’s rights, and the process for obtaining the first and or second level dispute resolution peer review panel, are provided to the practitioner. Notification to the practitioner will be mailed by an overnight carrier or certified mail, with return-receipt requested.

The practitioner has 30 days from the date of WellCare’s notice to submit a written request to WellCare. This request must be sent by a nationally recognized overnight carrier or U.S. certified mail, with return receipt, to invoke the dispute resolution peer review panel process.

Upon WellCare’s timely receipt of the request, WellCare’s medical director or his or her designee shall notify the practitioner of the date, time, and telephone access number for the panel hearing. WellCare then notifies the practitioner of the schedule for the review panel hearing.

The practitioner and WellCare are entitled to legal representation at the review panel hearing. The practitioner has the burden of proof 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. WellCare’s medical director, within five business days after final adjournment of the dispute resolution peer review panel hearing, shall notify the practitioner of the results of the first level panel hearing. In the event the findings are positive for the practitioner, the second-level panel 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 her or his 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. 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 all rights to such review to which he or she might otherwise have been entitled. WellCare may terminate the practitioner 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* of this Manual for further details.
Section 7: Reconsiderations (Appeals) and Grievances

Appeals

Provider Retrospective Appeals Overview
A Provider may appeal a claim or utilization review denial on his or her own behalf by mailing or faxing WellCare a letter of appeal or an appeal form with supporting documentation such as medical records. Appeal forms are located on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Forms” under “Medicare” in the “Providers” drop-down menu.

Providers have 90 calendar days from WellCare’s original utilization management review decision or claim denial to file a Provider appeal. Appeals after that time will be denied for untimely filing. If the Provider feels that the appeal was filed within the appropriate timeframe, the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of WellCare, or a similar receipt from other commercial delivery services.

Upon receipt of all required documentation, WellCare has up to 60 calendar days to review the appeal for Medical Necessity and conformity to WellCare guidelines and to render a decision to reverse or affirm. Required documentation includes the Member’s name and/or identification number, date of services, and reason why the Provider believes the decision should be reversed. Additional required information varies based on the type of appeal being requested. For example, if the Provider is requesting a Medical Necessity review, medical records should be submitted. If the Provider is appealing a denial based on untimely filing, proof of timely filing should be submitted. If the Provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

Appeals received without the necessary documentation will not be reviewed by WellCare due to lack of information. It is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the denial to review the appeal. Records and documents received after that time will not be reviewed and the appeal will remain closed.

Medical records and patient information shall be supplied at the request of WellCare or appropriate regulatory agencies when required for appeals. The Provider is not allowed to charge WellCare or the Member for copies of medical records provided for this purpose.

Provider Retrospective Appeals Decisions

Reversal of Initial Denial
If it is determined during the review that the Provider has complied with WellCare protocols and that the appealed services were Medically Necessary, the initial denial will be reversed. The Provider will be notified of this decision in writing.

The Provider may file a claim for payment related to the appeal, if one has not already been submitted. After the decision to reverse the denial has been made, any claims previously denied
will be adjusted for payment. WellCare will ensure that claims are processed and comply with federal and state requirements, as applicable.

**Affirmation of Initial Denial**
If it is determined during the review that the Provider did not comply with WellCare protocols and/or Medical Necessity was not established, the initial denial will be upheld. The Provider will be notified of this decision in writing.

For denials based on Medical Necessity, the criteria used to make the decision will be provided in the letter. The Provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

**Member Reconsideration Process**

**Overview**
A Member reconsideration, also known as an appeal, is a formal request from a Member for a review of an action taken by WellCare. A reconsideration may also be filed by an authorized representative or a Provider with the Member’s consent. All appeal rights described in *Section 7* of this Manual that apply to Members will also apply to the Member’s authorized representative or a Provider acting on behalf of the Member with the Member’s consent.

To request an appeal of a decision made by WellCare, a Member may file a reconsideration request orally or in writing within 60 days from the date of the Notice of Action. If the Member’s request is made orally, WellCare will mail an acknowledgment letter to the Member to confirm the facts and basis of the appeal.

Examples of actions that can be appealed include, but are not limited to:

- 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 CMS

WellCare gives Members reasonable assistance in completing forms and other procedural steps for a reconsideration, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability.

WellCare ensures that decision-makers assigned to reconsiderations were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of Medical Necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the reviewers will be health care professionals with clinical expertise in treating the Member’s condition/disease or will seek advice from Providers with expertise in the field of medicine related to the request.

WellCare will not retaliate against any Provider acting on behalf of or in support of a Member requesting a reconsideration or an expedited reconsideration.

**Appointment of Representative**
If the Member wishes to use a representative, he or she must complete a *Medicare Appointment of Representative (AOR)* form. The Member and the person who will be
representing the Member must sign the AOR form. The form is located on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Forms” under “Medicare” in the “Providers” drop-down menu. Prior to the service(s) being rendered, physicians may appeal on behalf of the Member if they have the Member’s consent in their records.

**Types of Appeals**
A Member may request a standard pre-service, retrospective, or an expedited appeal.

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

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

Only pre-service appeals are eligible to be processed as expedited appeals.

**Appeal Decision Timeframes**
WellCare will issue a decision to the Member or the Member’s representative within the following timeframes:
- Standard Pre-Service Request: **30 calendar days (7 calendar days for Pharmacy Appeals)**
- Retrospective Request: **60 calendar days (7 calendar days for Pharmacy Appeals)**
- Expedited Request: **72 hours**

**Standard Pre-Service and Retrospective Reconsiderations**
A Member may file a reconsideration request either verbally or in writing within 60 calendar days of the date of the adverse determination by contacting the Customer Service Department.

A Member may also present his or her appeal in person. To do so, the Member must call WellCare to advise that the Member would like to present the reconsideration in-person or via the telephone. If the Member would like to present her or his appeal in-person, WellCare will arrange a time and date that works best for the Member and WellCare. A Member of the management team and a WellCare Medical Director will participate in the in-person appeal.

After the Member presents the information, WellCare will mail the decision to the Member within the timeframe specified above, based on the type of appeal.

If the Member’s request for reconsideration is submitted after 60 calendar days, then good cause must be shown in order for WellCare to accept the late request. Examples of good cause include, but are not limited to:
- The Member did not personally receive the adverse organization determination notice or received it late
- The Member was seriously ill, which prevented a timely appeal
- There was a death or serious illness in the Member’s immediate family
- An accident caused important records to be destroyed
- Documentation was difficult to locate within the time limits
- The Member had incorrect or incomplete information concerning the reconsideration process

**Expedited Reconsiderations**
To request an expedited reconsideration, a Member or a Provider (regardless of whether the Provider is affiliated with WellCare) must submit a verbal or written request directly to WellCare. A request to expedite a reconsideration of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member’s life, health or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision to the Member.

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

If a reconsideration is expedited, WellCare will complete the expedited reconsideration and give the Member (and the Provider involved, as appropriate) notice of the decision as expeditiously as the Member’s health condition requires, but no later than 72 hours after receiving a valid and complete request for reconsideration.

If WellCare denies the request to expedite a reconsideration, WellCare will provide the Member with verbal notification within 24 hours. Within three calendar days of the verbal notification, WellCare will mail a letter to the Member explaining:
- That WellCare will automatically process the request using the 30 calendar day timeframe for standard reconsiderations;
- The Member’s right to file an expedited grievance if he or she disagrees with WellCare’s decision not to expedite the reconsideration and provides instructions about the expedited grievance process and its timeframes; and
- The Member’s right to resubmit a request for an expedited reconsideration and that if the Member gets any Provider’s support indicating that applying the standard timeframe for making a determination could seriously jeopardize the Member’s life, health or ability to regain maximum function, the request will be expedited automatically.

**Member Reconsideration Decisions**

**Reconsideration Levels**
There are five levels of reconsideration available to Medicare beneficiaries enrolled in Medicare Advantage plans after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:
1. Reconsideration of adverse organization determination by WellCare
2. Reconsideration of adverse organization determination by the independent review entity (IRE)
3. Hearing by an administrative law judge (ALJ), if the appropriate threshold requirements set forth in §100.2 have been met
4. Medicare appeals council (MAC) review
5. Judicial review, if the appropriate threshold requirements have been met

**Standard Pre-Service or Retrospective Reconsideration Decisions**
If WellCare reverses its initial decision, WellCare will either issue an authorization for the pre-service request or send payment if the service has already been provided.
If WellCare affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals) (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 30 days from receipt of the appeal to issue a final determination
- Notify the Member of the decision to affirm the initial denial and that the case has been forwarded to the IRE

Once a final determination has been made, the IRE will notify the Member and WellCare. In the event the IRE agrees with WellCare, the IRE will provide the Member further appeal rights.

If the IRE reverses the initial denial, the IRE will notify the Member or representative in writing of the decision. WellCare will also notify the Member or Member’s representative in writing that the services are approved along with an authorization number.

**Expeditied Reconsideration Decisions**

If WellCare reverses its initial action and/or denial, it will notify the Member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

If WellCare affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals) (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination
- Notify the Member of the decision to affirm the initial denial and that the case has been forwarded to the IRE

Once a final determination has been made, the IRE will notify the Member and WellCare. In the event the IRE agrees with WellCare, the IRE will provide the Member further appeal rights. If the IRE reverses the initial denial, the IRE notifies the Member or representative in writing of the decision.

**Grievances**

**Provider**

Medicare Advantage Providers are not able to file a grievance per CMS guidance.

**Member Grievance Overview**

The Member may file a grievance. A grievance may also be filed on the Member’s behalf by an authorized representative or a Provider with the Member’s written consent. All grievance rights described in Section 7 of this Manual that apply to Members will also apply to the Member’s authorized representative or a Provider acting on behalf of the Member with the Member’s consent. If the Member wishes to use a representative, then she or he must complete a Medicare Appointment of Representative (AOR) statement. The Member and the person who will be representing the Member must sign the AOR statement. The form is located on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Forms” under “Medicare” in the “Providers” drop-down menu.

Examples of issues that may result in a grievance include, but are not limited to:

- Provider Service including, but not limited to:
A Member or a Member’s representative may file a standard grievance request either orally (via Customer Service or in person) or in writing within 60 calendar days of the date of the incident or when the Member was made aware of the incident. Contact information for the Grievance Department is on the state-specific Quick Reference Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

Grievance Resolution

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

An extension of up to 14 calendar days may be requested by the Member or the Member’s representative. WellCare may also initiate an extension if the need for additional information can be justified and the extension is in the Member’s best interest. In all cases, extensions must be well-documented. WellCare will provide the Member or the Member’s representative prompt written notification regarding WellCare’s intention to extend the grievance decision.

The Grievance Department will inform the Member of the determination of the grievance as follows:

- All grievances submitted, either verbally or in writing, will be responded to in writing; and
- All grievances related to quality of care will include a description of the Member’s right to file a written complaint with the Quality Improvement Organization (QIO). For any complaint submitted to a QIO, WellCare will cooperate with the QIO in resolving the complaint.

WellCare provides all Members with written information about the grievance procedures/process available to them, as well as the complaint processes. WellCare also provides written information to Members and/or their appointed representative(s) about the grievance procedure at initial enrollment, upon involuntary disenrollment initiated by WellCare, upon the denial of a Member’s request for an expedited review of a determination or appeal, upon the Member’s request, and annually thereafter. WellCare will provide written information to Members and/or their appointed representatives about the QIO process at initial enrollment and annually thereafter.
The facts surrounding a complaint will determine whether the complaint is for coverage determination, organization determination or an appeal and will be routed appropriately for review and resolution.

**Expedited**

A Member may request an expedited grievance if WellCare makes the decision not to expedite an organizational determination, expedite an appeal, or invoke an extension to a review. WellCare will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review timeframe or extend a review timeframe does not jeopardize the Member’s health.

WellCare will contact the Member or the Member’s representative via telephone with the determination and will mail the resolution letter to the Member or the Member’s representative within three business days after the determination is made. The resolution will also be documented in the Member’s record.
Section 8: Compliance

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

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

- **HIPAA Privacy and Security Training**
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA and subsequent amendments to HIPAA
  - Training includes, but is not limited to discussion on:
    - Proper uses and disclosures of PHI
    - Member rights
    - Physical and technical safeguards

- **Fraud, Waste and Abuse (FWA) Training**
  - Must include, but not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.)
    - Obligations of the Provider including Provider employees and Provider subcontractors and their employees to have appropriate policies and procedures to address fraud, waste, and abuse
    - Process for reporting suspected fraud, waste and abuse
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse
    - Types of fraud, waste and abuse that can occur

Providers, including Provider employees and/or Provider sub-contractors, must report to WellCare any suspected fraud, waste or abuse, misconduct or criminal acts by WellCare, or any Provider, including Provider employees and/or Provider sub-contractors, or by WellCare Members. Reports may be made anonymously through the WellCare Health Plans, Inc. FWA hotline at 1-866-678-8355. Details of the corporate ethics and compliance program may be found on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “About Us” under “Corporate Information” in the “Corporate” drop-down menu. From this page, select “WellCare Compliance” from the right navigation bar.

Marketing Medicare Advantage Plans
Medicare Advantage plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V (replacing regulations formerly at 42 CFR 422.80), and the CMS Managed Care Manual, Chapter 3, Medicare Marketing
Guidelines for MA Plans, MA-PDs, PDPs and 1876 Cost Plans (Marketing Guidelines), including without limitation materials governing “Provider Based Activities” in Section 70.11.1.

Providers must adhere to all applicable laws, regulations and CMS guidelines regarding MA plan marketing, including without limitation 42 CFR Part 422, Subpart V and the marketing guidelines.

CMS holds plan sponsors such as WellCare responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting Providers. Providers are not authorized to engage in any marketing activity on behalf of WellCare without the prior express written consent of an authorized WellCare representative, and then only in strict accordance with such consent.

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. Select the appropriate state from the drop-down menu and click on “ICD-10 Compliance” under “News and Education” in the “Providers” drop-down menu.

Code of Conduct and Business Ethics

Overview
WellCare has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. WellCare’s Code of Conduct and Business Ethics policy can be found at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “About Us” under “Corporate Information” in the “Corporate” drop-down menu. From this page, select “WellCare Compliance” from the right navigation bar.

The Code of Conduct and Business Ethics is the foundation of iCare, WellCare’s Corporate Ethics and Compliance Program. It describes WellCare’s firm commitment to operate in accordance with the laws and regulations governing its business and accepted standards of business integrity. All associates, covered persons as defined by the CIA, participating Providers and other contractors should familiarize themselves with WellCare’s Code of Conduct and Business Ethics. WellCare associates, covered persons, participating Providers and other contractors of WellCare are encouraged to report compliance concerns and any suspected or actual misconduct using the compliance hotline at 1-866-364-1350. Report suspicions of fraud, waste and abuse by calling WellCare’s FWA hotline at 1-866-678-8355.

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

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

In addition, Providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating Providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504) Providers and their employees must complete an annual FWA training program.

To report suspected fraud and abuse, please call the confidential and toll-free WellCare compliance hotline at 1-866-364-1350 or refer to the state-specific Quick Reference Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu. Details of the corporate ethics and compliance program, and how to contact WellCare fraud hotline, may be found on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “About Us” under “Corporate Information” in the “Corporate” drop-down menu. From this page, select “WellCare Compliance” from the right navigation bar.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member or her or his case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended. All Provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of Members’ medical records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider practice is required to provide Members with information regarding their privacy practices and to the extent required by law, with their notice of privacy practices (NPP).
Employees who have access to Member records and other confidential information are required to sign a confidentiality statement.

Examples of confidential information include, but are not limited to the following:

- Medical records
- Communication between a Member and a physician 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 behavioral care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.)
- Member transfer to a facility for treatment of drug abuse, alcoholism, behavioral or psychiatric problem
- Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law

The NPP informs the patient or Member of their Member rights under HIPAA and how the Provider and/or WellCare may use or disclose the Member’s PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or Member.

**Disclosure of Information**

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

For more information on how to request this information, Members may contact Customer Service using the toll-free telephone number found on the Member’s ID card. Providers may contact Provider Services by referring to the state-specific Quick Reference Guides on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.
Section 9: Delegated Entities

Overview
WellCare may, by written contract, delegate certain functions under WellCare’s contracts with CMS and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, 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 and adjudicating Medicare organization determinations, and appeals and grievances (the delegated services). WellCare may delegate all or a portion of these activities to another entity (a delegated entity).

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

Compliance
WellCare’s compliance responsibilities extend to delegated entities, including, without limitation:
- Compliance plan
- HIPAA privacy and security
- Fraud, waste and abuse training
- Cultural competency plan
- Disaster recovery and business continuity

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

WellCare ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The Delegation Oversight Department will:
- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs
- Ensure that WellCare has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and WellCare, reporting requirements, and delegated activities in a clear and understandable manner
- Ensure that the appropriate WellCare associates have properly evaluated the entity’s ability to perform the delegated activities prior to delegation
- Provide formal, ongoing monitoring of the entity’s performance at least annually, including monitoring to ensure quality of care and quality of service is not compromised by financial incentives
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity’s performance is inadequate
Section 10: Dual-Eligible Members

**Overview**
Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit are often referred to as “dual-eligible Members.” These benefits are sometimes referred to as Medicare Savings Programs (MSPs). Dual-eligible Members are eligible for some form of Medicaid benefit, whether that Medicaid coverage is limited to certain costs, such as Medicare premiums, or the full benefits covered under the state Medicaid plan.

**Types of Dual-Eligible Members**
States administer MSPs for Medicare and Medicaid-eligible Members with limited income and resources to help pay for their Medicare cost-sharing. There are multiple MSP categories and the categories are based upon the beneficiary’s income and asset levels as well as “medically needy” status. Members learn of their MSP assistance from an award letter they receive from the state Medicaid agency.

For full definitions of the current categories of dual-eligible Members contained herein, see Section 13: Definitions and Abbreviations in this Manual.

See the chart below for the different categories of dual-eligible Members:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>QMB Plus (QMB+)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary (SLMB)</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>SLMB Plus (SLMB+)</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Qualifying Individual (QI)</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Qualified Disabled Working Individual (QDWI)</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Full Benefit Dual-Eligible Members (FBDE)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

In general, QMB, QMB+, SLMB+ and FBDE beneficiaries are considered “zero cost-share” dual-eligible Members since they do not pay Part A or Part B cost-share. Please note, the state Medicaid agency defines all state optional MSP levels and those levels may vary among states. Please contact the state Medicaid agency for full MSP information.

**Payments and Billing**
For all zero cost-share dual-eligible Members (QMB, QMB+, SLMB+ and FBDE), Medicaid is responsible for deductible, coinsurance, and co-payment amounts for Medicare **Parts A and B**
Covered Services. The filed cost-sharing amounts related to supplemental benefits (e.g. hearing, vision and extra dental) are the responsibility of the Member.

Providers may not “balance bill” these Members. This means Providers may not bill these Members for either the balance of the Medicare rate or the Provider’s customary charges for Part A or B services. The Member is protected from liability for Part A and B charges, even when the amounts the Provider receives from Medicare and Medicaid are less than the Medicare rate or less than the Provider’s customary charges. Providers who bill these Members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

Providers agree to accept WellCare’s payment as payment in full or will bill the appropriate state source for the cross-over cost-sharing payment. To bill the state, the Provider will submit the EOP provided by WellCare to the state.

If WellCare has assumed the state’s financial responsibility under an agreement between WellCare and the state, WellCare shall be considered the “appropriate state source.” If WellCare has assigned responsibility to a delegated vendor, the delegated vendor shall be considered the “appropriate state source.”

Some DSNP Plans will have a Part B deductible amount applied prior to payment similar to how Medicare operates today (excluding Florida, Texas, and California). This deductible is considered a cost-sharing amount and covered by the state Medicaid agency or its designee if they have Managed Medicaid or by WellCare via an agreement with the state. Providers should bill WellCare as they do today and submit the EOP provided by WellCare to the state for payment. If WellCare is responsible for this amount via an agreement with the state, WellCare will pay this amount on behalf of the state.

Members who enroll after January of each year might have had their deductible amount paid for previously by the State or another health plan. In this instance Providers should follow the billing process identified above and then send Best Available Evidence (BAE) illustrating that the Member has met their deductible. An example of BAE could be a remittance from the state/health plan illustrating that they have met the Member’s deductible previously. If the BAE is submitted and approved, WellCare will readjudicate the claim and send appropriate payment to the Provider.

Services that apply to the DSNP Part B deductible include:

- Cardiac rehabilitation services
- Intensive cardiac rehabilitation services
- Pulmonary rehabilitation services
- Partial hospitalization
- Chiropractic services
- Occupational therapy services (Except in GA)
- Physician specialist services
- Outpatient behavioral health specialty services
- Podiatry services
- Other health care professional
- Psychiatric services
- Physical therapy and speech-language pathology services (Except in GA)
- Medicare covered outpatient diagnostic procedures/tests & lab services
Referral of Dual-Eligible Members

When a participating Provider refers a dual-eligible Member to another Provider for services, the Provider should make every attempt to refer the dual-eligible Member to a Provider who participates with both WellCare and the state Medicaid agency. Providers who participate with the state Medicaid plan can be located at the applicable state’s Medicaid website. The WellCare Medicare provider directory displays an indicator when the Provider participates in Medicaid.

Dual-Eligible Members Who Lose Medicaid Eligibility/Status

Many dual-eligible Members are Members of Dual Special Needs Plans (DSNPs). For more information on DSNPs, refer to Section 1: Welcome to WellCare.

CMS requires DSNP plans to provide a Member a period of at least 30 days and up to six months to allow those dual-eligible Members who have lost Medicaid eligibility or had a change in status an opportunity to regain their eligibility. This period is called the “Deeming Period”. A change in status occurs when a dual-eligible Member either loses Medicaid eligibility or when a change in Medicaid eligibility occurs that impacts the Member responsibility. As of January 1, 2012, WellCare will implement a three month Deeming Period for all DSNP plans.

During the Deeming Period, WellCare applies the appropriate payment methodology to process claims and pays 100 percent of the Medicare allowable for all plans except the Florida Select Plan to protect its Members from cost-sharing. Providers must accept WellCare’s payment as payment in full and may not balance bill the Member. During the Deeming Period, certain Members in the Florida Select Plan may be responsible for cost sharing.
## Dual-Eligible State-Specific Contract Obligations

<table>
<thead>
<tr>
<th>State</th>
<th>Note</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>WellCare of Florida, Inc. Providers may access a list of WellCare's benefit offerings at the following website: <a href="http://www.wellcare.com/Florida">www.wellcare.com/Florida</a>.</td>
<td>Information concerning Medicaid Provider participation is available on WellCare’s website: <a href="http://www.wellcare.com/Florida">www.wellcare.com/Florida</a>. Providers can access the following state site to obtain Medicaid benefit information: <a href="http://ahca.myflorida.com/Medicaid">ahca.myflorida.com/Medicaid</a>. WellCare’s Medicaid site is <a href="http://www.wellcare.com/Florida">www.wellcare.com/Florida</a>.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>WellCare of New Jersey, Inc. Providers must accept payment received from WellCare as payment in full for services included in the combined Medicare Advantage, NJ FamilyCare Plan A, and MLTSS benefit package. In the event WellCare does not reimburse for a Covered Service, Providers may not seek payment from Members, Member representatives, the New Jersey Division of Medical Assistance and Health Services, or any Local Department of Social Services office.</td>
<td>Information concerning Medicaid Provider participation is available on WellCare’s website: <a href="http://www.wellcare.com/New-Jersey">www.wellcare.com/New-Jersey</a>.</td>
</tr>
<tr>
<td>State</td>
<td>Note</td>
<td>Resources</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>New York (Liberty and Advocate Complete Products)</strong></td>
<td>WellCare of New York, Inc. Providers must accept payment received from WellCare for services included in the Combined Medicare Advantage and Medicaid Advantage benefit package as payment in full for services provided to Members. In the event WellCare does not reimburse for a service, Providers may not seek payment from State Department of Health, Local Departments of Social Services, Members, or Member representatives. NY Liberty –There is a select list of Medicaid benefits that are provided by the state Medicaid plan. The state Medicaid Program has responsibility for the payment of these benefits.</td>
<td>Information concerning Medicaid Provider participation is available on WellCare’s website: <a href="http://www.wellcare.com/New-York">www.wellcare.com/New-York</a>.</td>
</tr>
<tr>
<td><strong>Texas</strong></td>
<td>WellCare of Texas, Inc. Providers may access a list of WellCare’s benefit offerings at the following website: <a href="http://www.wellcare.com/Texas">www.wellcare.com/Texas</a>.</td>
<td>Information concerning Medicaid Provider participation is available on WellCare’s website at: <a href="http://www.wellcare.com/Texas">www.wellcare.com/Texas</a> and the state’s website at: <a href="http://www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx">www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx</a>.</td>
</tr>
<tr>
<td><strong>Tennessee</strong></td>
<td>Harmony Health Plan, Inc. Providers are directed to the addendum for the state of Tennessee only. This information is in regards to the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA). Please reference in conjunction with the Provider Manual.</td>
<td>Information concerning TN agreement with TennCare to provide for Medicaid benefits for its dual-eligible enrollees is available on WellCare’s website at: <a href="http://www.wellcare.com/Tennessee">www.wellcare.com/Tennessee</a>.</td>
</tr>
<tr>
<td><strong>Louisiana</strong></td>
<td>WellCare Health Insurance of Arizona, Inc., formerly WellCare of Louisiana, Inc. Providers may access a list of WellCare’s benefit offerings at the following website: <a href="http://www.wellcare.com/Louisiana">www.wellcare.com/Louisiana</a>.</td>
<td>Information concerning Medicaid Provider participation is available on WellCare’s website: <a href="http://www.wellcare.com/Louisiana">www.wellcare.com/Louisiana</a>, and the state’s website: <a href="http://www.lamedicaid.com/provweb1/default.htm">www.lamedicaid.com/provweb1/default.htm</a>.</td>
</tr>
</tbody>
</table>
### DSNP Care Management Program

#### Overview
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) became law in July of 2008. MIPPA mandates a health risk assessment, care plan, interdisciplinary care team for Members, and an evaluation of care effectiveness by the health plan.

WellCare’s Model of Care (MOC) is tailored specifically to the dual-eligible Members in an effort to meet the populations’ functional, psychosocial and medical needs in a Member-centric fashion.

**Health Risk Assessment: Conducted by WellCare** – WellCare’s Care Management MOC begins with the HRA. The HRA assesses Member risk in the following areas: functional, psychosocial, and medical. Once completed, the HRA is stratified and then reviewed by a care manager. The stratification/acuity of the HRA is an indicator of the needs of the Member and is verified with the comprehensive medical assessment. WellCare utilizes four levels of stratification/acuity starting with level 1 (low risk) and going to level 4 (high risk). The dual-eligible Member is then contacted so the Care Management process can begin. WellCare will conduct initial assessment within 90 days of enrollment and will conduct annual reassessment within one year of the initial assessment.

**Comprehensive Medical Assessment: Conducted by WellCare** – The care manager telephonically conducts the comprehensive medical assessment with the dual-eligible Member and/or caregiver, if appropriate, in order to collect additional social, medical, and behavioral information to generate a Member-centric individualized care plan (ICP). The comprehensive medical assessment is based on Clinical Practice Guidelines and allows the care plan to be generated utilizing these guidelines.

**Individualized Care Plans: Generated by WellCare** – Once the care manager, the Member, and/or caregiver complete the comprehensive medical assessment, an ICP is generated that reflects the Member’s specific problems, prioritized goals, and interventions. The care manager and the Member and/or caregiver, if appropriate, agree on the care plan and set goals. The ICP generated tracks dates and goal progress. The frequency of contact will vary depending on the stratification/acuity of the Member and specific goal timeframes. The ICP is shared with all Members of the interdisciplinary care team (ICT) for input and updates.

**Interdisciplinary Care Team: WellCare and Providers** – The care manager shares the ICP with all the Members of the ICT in an effort to provide feedback and promote collaboration regarding the Member’s goals and current health status. At a minimum, the ICT includes the Member, the Member’s caregiver (if appropriate), the Member’s PCP and WellCare care...
manager. Other Members of the ICT can include specialists, social service support, behavioral health specialists, and/or caregiver and others depending on the Member’s specific needs. The care manager communicates and coordinates with the Members of the ICT to educate the Member, provide advocacy, and assist them as they navigate the health care system.

Care Transitions: WellCare and Providers – The care manager is responsible for coordinating care when Members move from one setting to another and facilitates transitions through communication and coordination with the Member and their usual practitioner. During this communication with the Member, the care manager will discuss any changes to the Member’s health status and any resulting changes to the care plan. The care manager will notify the Member’s usual Provider of the transition and will communicate any needs to assist with a smoother transition process.

Provider Required Participation
To meet the intent of the MIPPA legislation, Providers are required to participate in the MOC for all DSNP plan Members. The expectations for participation are as follows:

- Complete the required MOC training. WellCare offers an online training module and a printable self-study packet. If Providers opt to use the self-study packet, WellCare requests they return the attestation via fax for reporting purposes. Both the online module and self-study packet can be accessed at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu. If Providers would like to request a copy mailed, at no cost, they can contact Provider Services or their Provider Relations representative
- Become familiar with WellCare’s Clinical Practice Guidelines which are based on nationally-recognized evidence-based guidelines
- Read newsletters that feature articles regarding the latest treatments for patients;
- Review and update the Member care plan faxed by the Care Management Department
- Participate in the ICT for all DSNP Members in a Provider’s membership panel and give feedback as appropriate. The care manager will communicate with the members of the ICT for any updates to the ICP and will be available to assist the dual-eligible Member to meet the goals of the ICP

Re-cap of the benefits of the DSNP Care Management Program:

- All Members receive a Health Risk Assessment
- Members are stratified according to the severity of their disease process, functional ability, and psychosocial needs
- A comprehensive medical assessment is completed by the care manager and is the basis for the ICP
- The ICP is generated by the care manager in collaboration with the Member and the care team
- The ICP is shared with the ICT for review and comments as needed
- The care manager continues to monitor, educate, coordinate care and advocate on behalf of the Member
Section 11: Behavioral Health

Overview
WellCare provides a behavioral health benefit for Medicare plans. For information regarding how to contact the behavioral health services administrator for each market, please refer to the state-specific Quick Reference Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

Behavioral Health Program
Some behavioral health services may require Prior Authorization, including all services provided by non-participating Providers.

For complete information regarding benefits and exclusions, or in the event a Provider needs to contact WellCare’s Customer Service for a referral to a behavioral health Provider, refer to the Quick Reference Guide, which may be found on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

Coordination of Care Between Medical and Behavioral Health Providers
PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health Providers may provide physical health care services if, and when, they are licensed to do so within the scope of their practice. Behavioral health Providers are required to use the latest version of the Diagnostic and Statistical Manual of Mental Disorders when assessing the Member for behavioral health services and document the diagnosis and assessment/outcome information in the Member’s medical record.

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

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

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 co-morbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and impact Member outcomes.
**Responsibilities of Behavioral Health Providers**
WellCare monitors Providers against these standards to ensure Members can obtain needed health services within the acceptable appointments waiting times. The provisions below are applicable only to behavioral health Providers and do not replace the provisions set forth in *Section 2: Provider and Member Administrative Guidelines* for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health Provider – Urgent</td>
<td>&lt; 48 hours</td>
</tr>
<tr>
<td>Behavioral health Provider – Post Inpatient discharge</td>
<td>&lt; 7 days</td>
</tr>
<tr>
<td>Behavioral health Provider – Routine</td>
<td>&lt; 10 days</td>
</tr>
<tr>
<td>Behavioral health Provider – Non-Life Threatening Emergency</td>
<td>&lt; 6 hours</td>
</tr>
<tr>
<td>Behavioral health Provider – Screening and Triage of Calls</td>
<td>&lt; 30 seconds</td>
</tr>
</tbody>
</table>

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

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

Behavioral health Providers are expected to assist Members in accessing emergent, urgent, and routine behavioral services as expeditiously as the Member’s condition requires. Members also have access to a toll free behavioral crisis hotline that is staffed 24 hours per day. The behavioral crisis phone number is printed on the Member’s card and is available on WellCare’s website.

For information about WellCare’s Care Management and Disease Management programs, including how to refer a Member for these services, please see *Section 4: Utilization Management, Care Management and Disease Management.*
Section 12: Pharmacy

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

- Formulary
- Prior Authorization
- Step therapy
- Quantity limit
- Mail service

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

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

To contact WellCare’s Pharmacy Department, please refer to the state-specific Quick Reference Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

For more information on WellCare’s benefits, visit WellCare’s website at www.wellcare.com.

Formulary

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

The P&T Committee’s selection of drugs is based on the drug’s efficacy, safety, side effects, pharmacokinetics, clinical literature, and cost-effectiveness profile. The medications on the formulary are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, prior authorization and step therapy).

The formulary is located on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Pharmacy” under “Medicare” in the “Providers” drop-down menu.

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

- Quarterly updates in Provider and Member newsletters
- Website updates
- Pharmacy and Provider communication that detail any major changes to a particular therapy or therapeutic class
Additions and Exceptions to the Formulary
To request consideration for inclusion of a drug to WellCare’s formulary, Providers may write WellCare, explaining the medical justification. For contact information, refer to the state-specific Quick Reference Guides on WellCare’s website at www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

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

Coverage Limitations
The following is a list of non-covered (i.e., excluded) drugs and/or categories:
• Agents when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose (i.e., morbid obesity))
• Agents when used to promote fertility
• Agents when used for cosmetic purposes or hair growth
• Agents when used for the symptomatic relief of cough and colds
• Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
• Nonprescription over-the-counter (OTC) drugs
• Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
• Agents when used for the treatment of sexual or erectile dysfunction. Erectile dysfunction drugs will meet the definition of a Part D drug when prescribed for medically-accepted indications approved by the Food and Drug Administration (FDA) other than sexual or erectile dysfunction (such as pulmonary hypertension)

Generic Medications
WellCare covers both brand name drugs and generic drugs. A generic drug is approved by the (FDA) as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Step Therapy
Step Therapy programs are developed by the P&T Committee. These programs encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before “stepping up” to less cost-effective alternatives. Step therapy programs are intended to be a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on WellCare’s formulary have been evaluated through the use of clinical literature and are approved by WellCare’s P&T Committee.

Medicare Part D drugs requiring step therapy are designated by the letters “ST” on WellCare’s formulary.

Prior Authorization
Prior authorization protocols are developed and reviewed annually by the P&T Committee. Prior authorization protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s)).
Part D drugs requiring prior authorization are designated by the letters “PA” on WellCare’s formulary.

**Quantity Limits**
Quantity limits are used to encourage that pharmaceuticals are supplied in a quantity consistent with FDA-approved dosing guidelines. Quantity limits are used to help prevent billing errors.

Part D drugs that have quantity limits are designated by the letters “QL”, and the quantity permitted, on WellCare’s formulary.

**Therapeutic Interchange**
Therapeutic interchange is not a Formulary Benefit Management tool which WellCare utilizes.

**Mail Service**
Part D drugs that are available through mail order are designated by the letters “MS” in the Requirements/Limits column of WellCare’s formulary.

Members who utilize WellCare’s preferred mail service pharmacy, CVS Caremark may be eligible for reduced co-payment amounts. A Member Registration, Prescription Mail Order Form and a Mail Service Pharmacy Prescription Form are located on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Pharmacy” under “Medicare” in the “Providers” drop-down menu.

**Injectable and Infusion Services**
Self-injectable medications, specialty medications, and home infusion medications are covered as part of the outpatient pharmacy benefit. Non-formulary injectable medications and those listed on the formulary with a prior authorization will require submission of a request form for review. For more information, refer to the Obtaining a Coverage Determination Request section below.

**Over-the-Counter Medications**
Medications available to the Member without a prescription are not eligible for coverage under the Member’s Medicare Part D benefit.

Please refer to the Member’s state-specific Summary of Benefits for additional information about an additional pharmacy wrap benefit for over-the-counter medications located on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Find My Plan” under “Medicare” in the “Members” drop-down menu.

**Member Co-Payments**
The co-payment and/or coinsurance are based on the drug’s formulary status, including tier location, and the Member’s subsidy level. Refer to the Member’s state-specific Summary of Benefits for the exact co-pay/coinsurance located on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Find My Plan” under “Medicare” in the “Members” drop-down menu.

**Coverage Determination Request Process**
The goal of the Coverage Determination Request program is to ensure that medication regimens that are high-risk, have a high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.
The Coverage Determination request process is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary with a prior authorization
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits or prescriptions exceeding the permitted QL noted on the formulary
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician’s office
- Drugs that have a step edit and the first line therapy is inappropriate

**Obtaining a Coverage Determination Request**

Complete a *Coverage Determination Request Form* and fax it to the Pharmacy Department. The form is on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Pharmacy” under “Medicare” in the “Providers” drop-down menu. For the appropriate fax number, refer to the state-specific *Quick Reference Guides* on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.

The Provider must provide medical history and/or other pertinent information when submitting a *Coverage Determination Request Form* for medical exception.

If the Coverage Determination Request meets the approved P&T Committee’s protocols and guidelines, the Provider and/or pharmacy will be contacted with the Coverage Determination request approval. An approval letter is also sent to the Member and a telephonic attempt is made to inform them of the approval.

If the Coverage Determination Request is not a candidate for approval based on approved P&T Committee protocols and guidelines, it is reviewed by a clinical pharmacist.

For those requests that are not approved, a follow-up *Drug Utilization Review (DUR)* Form is faxed to the Provider stating why the Coverage Determination Request was not approved, including a list of the preferred drugs that are available as alternatives, if applicable. A denial letter is also sent to the Member and a telephonic attempt is made to inform them of the denial.

**Medication Appeals**

To request an appeal of a Coverage Determination Request decision, contact the Pharmacy Appeals Department via fax, mail, in person or phone. Refer to the state-specific *Quick Reference Guides* on WellCare’s website at [www.wellcare.com](http://www.wellcare.com). Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu. for more information.

Once the appeal of the Coverage Determination Request decision has been properly submitted and obtained by WellCare, the request will follow the appeals process described in *Section 7: Reconsiderations (Appeals) and Grievances.*
Section 13: Definitions and Abbreviations

Definitions

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

**Appeal** means a request for review of some action taken by or on behalf of WellCare.

**Benefit Plan** means a health benefit policy or other health benefit contract or coverage document (a) issued by WellCare or (b) administered by WellCare pursuant to a government contract. Benefit plans and their designs are subject to change periodically.

**Centers for Medicare and Medicaid Services (CMS)** means the United States federal agency which administers Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).

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

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

**Covered Services** means Medically Necessary health care items and services covered under a benefit plan.

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

**Encounter Data** means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

**FBDE** means full benefit dual-eligible Members who are eligible to have full Medicaid benefits (SLMB+ and QMB+).
Formulary means a list of covered drugs selected by WellCare in consultation with a team of health care Providers on the Pharmacy and Therapeutics (P&T) Committee, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

Grievance means any complaint or dispute, other than one that involves a WellCare determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of WellCare, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

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

Medically Necessary or Medical Necessity means those health care items or services that are (i) necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain, (ii) individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the Member’s needs, (iii) consistent with generally accepted professional medical standards and not experimental or investigational, (iv) reflective of the level of service that can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide, (v) provided in a manner not primarily intended for the convenience of the Member, the Member’s caretaker or the health care Provider, and (vi) not custodial care as defined by CMS. For health care items and services provided in a hospital on an inpatient basis, “Medically Necessary” also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a health care Provider has prescribed, recommended or approved health care items or services does not, in itself, make such items or services Medically Necessary.

Member means an individual properly enrolled in a benefit plan and eligible to receive Covered Services at the time such services are rendered.

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

Members with Special Health Care Needs means adults and children who face daily physical, behavioral or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

PCP means a primary care Provider.
Provider means an individual or entity that has contracted, directly or indirectly, with Health Plan to provide or arrange for the provision of Covered Services to Members under a benefit plan.

QI means Qualifying Individual whose income is between 120% and 135% of the Federal Poverty Level. These individuals are considered partial dual-eligible Members since they are responsible for paying their Part A and Part B cost sharing. These Members are not eligible to have full Medicaid benefits.

QMB+ means Qualified Medicare Beneficiary whose income is no more than 80% of the Federal Poverty Level. These individuals are considered a zero cost share dual-eligible Members since they are not responsible for paying their Part A or Part B cost sharing. They also are eligible to have full Medicaid benefits.

QMB means Qualified Medicare Beneficiary whose income is between 80 percent and 100 percent of the Federal Poverty Level. These individuals are considered a zero cost share dual-eligible Members since they are not responsible for paying their Part A or Part B cost sharing. These Members are not eligible to have full Medicaid benefits.

Reopening means a remedial action taken to reconsider a final determination or decision even though the determination or decision was correct based on the evidence of record.

SLMB+ means Specified Low-Income Medicare Beneficiary whose income is between 100 percent and 120 percent of the Federal Poverty Level. These individuals are considered a zero cost-share dual-eligible Members since they are not responsible for paying their Part A or Part B cost sharing. They also are eligible to have full Medicaid benefits.

SLMB means Specified Low-Income Medicare Beneficiary whose income is between 100 percent and 120 percent of the Federal Poverty Level. These individuals are considered partial dual-eligible Members since they are responsible for paying their Part A and Part B cost sharing. These Members are not eligible to have full Medicaid benefits.

QDWI means Qualified Disabled Working Individual whose income is between 135 percent and 200 percent of the Federal Poverty Level. These individuals considered partial dual-eligible Members since they are responsible for paying their Part A and Part B cost sharing. These Members are not eligible to have full Medicaid benefits.

WellCare Companion Guide means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and encounter data submitted to WellCare or its affiliates, as amended from time to time.

Zero Cost Share Dual-Eligible Member means a dual-eligible Member that is not responsible for paying any Part A or Part B cost sharing.
Abbreviations

ACS - American College of Surgeons
AEP – Annual enrollment period
Agreement – Provider Participation Agreement
AHP – Allied health professional
AIDS - Acquired Immune Deficiency Syndrome
ALJ – Administrative law judge
AMA – American Medical Association
ARNP – Advanced Registered Nurse Practitioner
CAD – Coronary artery disease
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CDSC – Controlled Dangerous Substance
CHF – Congestive heart failure
CIA – Corporate Integrity Agreement
CLAS – Culturally and linguistically appropriate services
CMS – Centers for Medicare and Medicaid Services
CNM – Certified Nurse Midwife
COB – Coordination of benefits
COPD – Chronic obstructive pulmonary disease
CORF – Comprehensive outpatient rehabilitation facility
CSR – Controlled Substance Registration
DDE – Direct data entry
DEA – Drug Enforcement Agency
DM – Disease Management
DME – Durable medical equipment
DOC – Delegation Oversight Committee
DSM-IV - Diagnostic and Statistical Manual of Mental Disorders
DSNP – Dual-Eligible Special Needs Plans
EDI – Electronic data interchange
EOB – Explanation of Benefits
EOP – Explanation of Payment
ESRD – End-stage renal disease
FBDE – Full Benefit Dual-Eligible Members
FDA – Food and Drug Administration
FFS – Fee-for-service
FWA – Fraud, waste, and abuse
HEDIS® - Healthcare Effectiveness Data and Information Set
HHA – Home health agency
HHS – US Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act of 1996
HIV – Human Immunodeficiency Virus
HMO – Health maintenance organization
HMO-POS – Health maintenance organization with point of service option
HOS – Medicare Health Outcomes Survey
HRA – Health Risk Assessment
HTN – Hypertension
ICD-10-CM – International Classification of Diseases, 10th Revision, Clinical Modification
ICP – Individualized Care Plans
ICT – Interdisciplinary Care Team
INR – Inpatient nursing rehabilitation facility
IPA – Independent physician association
IRE – Independent Review Entity
IVR – Interactive voice response
JNC – Joint National Committee
LCSW – Licensed Clinical Social Worker
LTAC – Long term acute care facility
MA – Medicare Advantage
MAC – Medicare Appeals Council
MIPPA – Medicare Improvements for Patients and Providers Act of 2008
MOC – Model of Care
MOOP – Maximum out of pocket
MSP – Medicare Savings Programs
NCCI – National Correct Coding Initiative
NCQA – National Committee for Quality Assurance
NDC – National Drug Codes
NIH – National Institutes of Health
NPI – National Provider Identifier
NPP – Notice of Privacy Practice
OA – Osteopathic Assistant
OB – Obstetric / obstetrical / obstetrician
OIG – Office of Inspector General
OT – Occupational therapy
OTC – Over-the-counter
P&T – Pharmacy and Therapeutics Committee
PA – Physician Assistant
PCP – Primary care Provider
PHI – Protected health information
POS – Point of service
PPC – Provider-preventable condition
Provider ID – Provider identification number
PT – Physical therapy
QDWI – Qualified Disabled Working Individual
QI – Qualifying Individual
QI Program – Quality Improvement Program
QIO – Quality Improvement Organization
QMB – Qualified Medicare Beneficiary
QMB+ - Qualified Medicare Beneficiary Plus
RN – Registered Nurse
SFTP – Secure file transfer protocol
SIE – Site inspection evaluation
SLMB – Specified Low-Income Medicare Beneficiary
SLMB+ - Specified Low-Income Medicare Beneficiary Plus
SNF – Skilled nursing facility
SNIP – Strategic National Implementation Process
SSN – Social Security Number
ST – Speech therapy
Tax ID / TIN – tax identification number
TNA – Transition Needs Assessment
TOC – Transition of care
UM – Utilization management
WEDI - Workgroup for Electronic Data Interchange
Section 14: WellCare Resources

WellCare Homepage
www.wellcare.com

Provider Homepage
www.wellcare.com/providers

Quick Reference Guides
Provider Manuals
Forms and Documents
Training and Education
www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu

Pharmacy
Exactus
www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu

Clinical Practice Guidelines
Clinical Care Guidelines
www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Clinical Guidelines” under “Tools” in the “Providers” drop-down menu

Claims
www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Claims” under “Medicare” in the “Providers” drop-down menu

Quality
www.wellcare.com. Select the appropriate state from the drop-down menu and click on “Quality” under “Medicare” in the “Providers” drop-down menu