2019 NEW YORK MEDICAID PROVIDER MANUAL
Dear Provider Partner:

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

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

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

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

Thank you again for being a trusted WellCare provider partner!

Sincerely,

Dr. Richard Petrucci
Chief Medical Officer
New York State

Quality Highlights

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- Responsibilities of all Providers
- Access Standards
- Cultural Competency Program and Plan
- Member Rights and Responsibilities

Section 3
- Quality Improvement

Section 4
- Prior Authorization
- Criteria for Utilization Management Determinations
- Access to Care and Disease Management Programs

Section 7
- Appeals and Grievances

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Quality care is a team effort.
Thank you for playing a starring role!
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WellCare Health Plans, Inc.
New York Medicaid Provider Manual

Effective: July 31, 2019
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Provider Services (toll free): 1-800-288-5441
## Revision Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Section</th>
<th>Comments</th>
<th>Page</th>
<th>Change</th>
</tr>
</thead>
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<tr>
<td>7/31/2019</td>
<td><strong>Section 4:</strong> UM, CM, DM</td>
<td>Amended: Criteria for UM Decisions</td>
<td>56</td>
<td>Added requirements to notify and submit necessary clinical information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notification</td>
<td>57</td>
<td>Added inpatient notification information</td>
</tr>
</tbody>
</table>
Section 1: About WellCare

WellCare Health Plans, Inc., provides managed care services targeted exclusively to government-sponsored health care programs focused on Medicaid and Medicare, including prescription drug plans, health plans for families, and the aged, blind and disabled. WellCare’s corporate office is located in Tampa, Florida. WellCare serves approximately 6.3 million Members. WellCare’s experience and commitment to government-sponsored health care programs enable the company to serve its Members and Providers as well as manage its operations effectively and efficiently.

Mission and Vision

WellCare’s vision is to be the leader in government-sponsored health care programs in partnership with the Members, Providers, governments and 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 Values are:

- Partnership – Members are the reason WellCare is in business; Providers are WellCare’s 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.
- One Team – WellCare and its associates can expect - and are expected to demonstrate - a collaborative approach in the way they work.

Purpose of this Manual

This Provider Manual is intended for WellCare-contracted (participating) Medicaid Providers delivering health care service(s) to WellCare Members enrolled in a WellCare Medicaid Managed Care plan or other health insurance program. This Manual serves as a guide to the policies and procedures governing the administration of WellCare’s plans and is an extension of and supplements the Provider Participation Agreement (Agreement) between WellCare and Providers. This Manual replaces and supersedes any previous versions dated prior to July 31, 2019, and is available on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid. Providers may request a paper copy at no charge by contacting the WellCare Provider Services Department or a Provider Relations representative.

In accordance with the Agreement, participating Medicaid Providers must abide by all applicable provisions of this Manual, as it may be modified from time to time upon notice. WellCare may change this Manual to reflect changes in its policies and procedures. Revisions shall become binding 30 days after WellCare’s notice to Providers, or such lesser time for WellCare’s compliance with laws, government contracts, or accreditation requirements.
Unless otherwise provided in the Agreement, WellCare will notify Providers of changes to this Manual through the New York Medicaid 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 of New York’s Health Plans**

In New York, WellCare’s Medicaid family of products includes:

- Healthy Choice
- Child Health Plus

WellCare has contracted with the New York State Department of Health (DOH) to provide these health insurance plans. These products are offered in select markets to allow flexibility and to offer a distinct set of benefits to fit Member needs in each area. The health plans offered are described below.

**Healthy Choice**

Healthy Choice serves both adults and children who are eligible to participate in New York’s Medicaid Program. Medicaid is a state and federal partnership which provides health coverage for selected categories of individuals and families with low income.

Eligible enrollees can choose to join Medicaid or a program such as Healthy Choice. With an enrollment in Healthy Choice, Members receive more benefits, more choice, more convenience and more coverage than traditional Medicaid. If they access their benefits within the Healthy Choice network, there is no additional cost. Members can choose their personal doctor from a network of family doctors, pediatricians and internists and then make appointments to see the doctor in his or her office.

**Child Health Plus**

The Child Health Plus (CHP) contract is issued pursuant to a special DOH program designed to provide health insurance coverage to children of families who do not receive health insurance benefits from their employers and who cannot afford private coverage premiums. This coverage applies to children under the age of 19 of families who do not receive other health insurance benefits, who are not eligible for Medicaid, who are permanent New York State residents and reside in WellCare’s service area.

**Covered Services**

As of Jan. 1, 2016:

<table>
<thead>
<tr>
<th>Benefit/Services</th>
<th>Child Health Plus Co-payments</th>
<th>Healthy Choice Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance - Emergency</td>
<td>$0</td>
<td>Covered through SDOH. Members should call 911.</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Benefit/Services</td>
<td>Child Health Plus Co-payments</td>
<td>Healthy Choice Co-payments</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Behavioral Health Services (Chemical Dependency)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One behavioral health visit and one substance abuse visit with a participating Provider per year for evaluation</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Not covered</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covered for children age 20 and under</td>
</tr>
<tr>
<td>Dental Services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Services – Rural Health Center (RHC), Federally Qualified Health Center (FQHC), Pediatric Care Center (PCC)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>EPSDT – Early and Periodic Screening, Diagnosis, and Treatment</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Family Planning</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice – Non-institutional</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hospital Services: Inpatient</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hospital Services: Outpatient</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Kidney Dialysis and Transplants</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Laboratory Diagnostic and Radiology Services (by physician or lab)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Not covered</td>
<td>$0</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$0 per Medically Necessary prescription</td>
<td>Ages 21+ Generics: $1 Brand: $3 Over-the-counter: $0.50 Members younger than 21 years of age have no co-payment</td>
</tr>
<tr>
<td>Preventive Services (wellness care)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
The Child Health Plus program covers treatment provided to screen, diagnose and treat autism spectrum disorders.

Treatment of autism spectrum disorder includes the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or psychologist:

- Behavioral health treatment
- Psychiatric care
- Psychological care
- Medical care provided by a licensed health Provider
- Therapeutic care, including care which is deemed habilitative or non-restorative
- Pharmacy care

Coverage will not be provided for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.

The administration of clotting factor products on an inpatient or outpatient basis is a covered service for members in the Child Health Plus or Healthy Choice plans. Infusion of said products may be performed by a home health care agency, a properly trained parent or legal guardian of a child, or a properly trained child/adult that is physically and developmentally capable of self-administering such products.

**Special Programs**
Effective Jan. 1, 2016, WellCare of New York will offer Medicaid Members the following special programs:

**Healthy Behaviors Program**
The Healthy Behaviors Program is designed to reward Members for taking small steps that will help them live a healthier life.

Members may earn rewards by completing a series of services tailored to promote obtaining the recommended well-child visits, child and adolescent health checkups for children up to 21 years of age, women’s cervical cancers, prenatal care and the management of chronic diseases such as diabetes.

**Weight Watchers**
WellCare offers a six-month Weight Watchers® membership benefit for Medicaid Members in order to support healthy lifestyles and improve health outcomes. Through the support of group meetings and access to Weight Watchers eTools,
Members will be encouraged to form healthy lifestyle habits, eat smarter and get more exercise.

**Member Transportation**

Non-emergent transportation was carved out of WellCare’s benefit package and phased into the fee-for-service Medicaid program. The service is no longer covered by WellCare but is covered by the State.

For Healthy Choice Members who reside outside of New York City in the counties where WellCare operates, the service is provided by Medical Answering Services (MAS). The Medical Answering Services website is [www.medanswering.com](http://www.medanswering.com). Below is the contact information for each county.

<table>
<thead>
<tr>
<th>County</th>
<th>Medical Answering Services Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany</td>
<td>1-855-360-3549</td>
</tr>
<tr>
<td>Dutchess</td>
<td>1-866-244-8995</td>
</tr>
<tr>
<td>Erie</td>
<td>1-800-651-7040</td>
</tr>
<tr>
<td>Rensselaer</td>
<td>1-855-852-3293</td>
</tr>
<tr>
<td>Rockland</td>
<td>1-855-360-3542</td>
</tr>
<tr>
<td>Ulster</td>
<td>1-866-287-0983</td>
</tr>
<tr>
<td>Orange</td>
<td>1-855-360-3543</td>
</tr>
</tbody>
</table>

For Healthy Choice Members who reside in New York City, the service is provided by LogistiCare. They can be reached at **1-877-564-5922**.

These changes do not affect how the Members receive their emergency transportation. Members who have an emergency and need an ambulance should dial 911.

**Non-Covered Services**

As of January 1, 2016:

- Non-Covered Services (listed below)
- Unauthorized services
- Services provided by non-participating Providers

<table>
<thead>
<tr>
<th>Healthy Choice</th>
<th>Child Health Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic surgery if not medically needed</td>
<td>Cosmetic surgery if not medically needed</td>
</tr>
<tr>
<td>Routine foot care (for those 21 and older)</td>
<td>Routine foot care</td>
</tr>
<tr>
<td>Infertility treatments</td>
<td>Infertility treatments</td>
</tr>
<tr>
<td>Services from a Provider who is not part of WellCare (unless WellCare or your PCP sends you to that Provider)</td>
<td>Inpatient or physician services in a nursing home or rehabilitation facility not covered by WellCare</td>
</tr>
<tr>
<td></td>
<td>Private duty nursing services</td>
</tr>
</tbody>
</table>
Provider Services
Providers may contact Provider Services at the phone number listed on the bottom of each page in this Provider Manual. Providers may also find important WellCare addresses, phone numbers, fax numbers and authorization requirements by referring to the Quick Reference Guide on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid.

Interactive Voice Response (IVR) System
IVR system
- Technology to expedite Provider verification and authentication within the IVR
- Provider/Member account information is sent directly to the agent’s desktop from the IVR validation process, so Providers do not have to re-enter information
- Full speech capability, allowing Providers to speak their information or use the touch-tone keypad

Self-Service Features
- Ability to receive Member co-pay information
- 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 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

For additional information on this enhanced technology, refer to the Phone Access Guide at www.wellcare.com/New-York/Providers/Medicaid under the Providers section, “Overview & Resources.”

Website Resources
On WellCare of New York’s website, www.wellcare.com/New-York, Providers have access to a variety of easy-to-use tools created to streamline day-to-day administrative tasks with WellCare. Public resources found on the website include:
Registration is required to use certain key features outlined below.

**Secure Provider Portal: Key Features and Benefits of Creating an Account**
WellCare of New York's secure, online Provider Portal provides immediate access to what Providers need most. All participating providers who creates an account can use the following features:

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

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

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

**Additional Resources**
The *New York Medicaid Resource Guide* contains information about WellCare’s secure online Provider Portal, Member eligibility, authorizations, filing paper and electronic
claims, appeals, and more. For specific instructions on how to complete day-to-day administrative tasks, please see the New York Medicaid Resource Guide found on WellCare's website at www.wellcare.com/New-York/Providers/Medicaid.
Section 2: Provider and Member Administrative Guidelines

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

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

- 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 Medicaid contract(s) and/or DOH rules and regulations, and assist WellCare in complying with corrective action plans necessary for WellCare to comply with such rules and regulations
- Retain all agreements, books, documents, papers and medical records related to the provision of services to WellCare Members as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii)]
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) should provide direct Member care within the scope or practice established by the rules and regulations of the DOH and WellCare guidelines
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations
- Clearly identify physician and extender titles (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, within the scope of practice, treatment for any Member in need of health care services
- Maintain the confidentiality of Member information and records
- Respond within the identified time frame to WellCare’s requests for medical records in order to comply with regulatory requirements
- Maintain accurate medical records and adhere to all WellCare’s policies governing 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
- 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 contain similar provisions to the Agreement.

The physician maintains written agreements with all contracted physicians or other health care practitioners and Providers.

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the Member, or the requesting party at no charge, unless otherwise agreed.
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not discriminate in any manner between WellCare Members and non-WellCare Members.
- Ensure that the hours of operation offered to WellCare Members is no less than those offered to commercial Members.
- Not deny, limit or condition the furnishing of treatment to any WellCare Member on the basis of any factor that is related to health status, including, but not limited to the following:
  - Medical condition, including mental as well as physical illness.
  - Claims experience.
  - Receipt of 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 Member’s behalf for Member’s health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services.
- Identify Members who are in need of services related to children’s health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs.
- Document the referral to WellCare-sponsored or community-based programs in the Member’s medical record and provide the appropriate follow-up to ensure the Member accessed the services.

**Excluded or Prohibited Services**
Providers must verify patient eligibility and enrollment prior to service delivery. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits are administered outside of the managed care program and are administered by the state. Providers should address issues related to those benefits with the state.
Responsibilities of All Providers
The following is a summary of responsibilities of all Providers who render services to WellCare Members. These are intended to supplement the terms of the Agreement, not replace them.

Provider Identifiers
All participating Providers are required to have a unique New York Medicaid Provider number and a National Provider Identifier (NPI). For more information on NPI requirements, refer to Section 5: Claims.

Advance Directive
Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their 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.

New York State HIV Testing Offer Law of 2010
Human Immunodeficiency Virus (HIV) testing must be offered to anyone between the ages of 13 and 64 receiving hospital or primary care services, with limited exceptions noted in the law. The offer must be made to Members who are inpatients, to Members seeking services in emergency departments, to Members receiving primary care as outpatients at a clinic, at a hospital, or from a physician, physician assistant, nurse practitioner or midwife.

Consent for HIV testing remains in effect until it is revoked or expires. Members can provide consent for HIV testing through any of the following methods:
- Oral consent. Consent can be obtained verbally for HIV tests, including point-of-care tests and tests that run on multiplatform analyzers, if they produce results in 60 minutes or less. Consent must be documented in the Member’s medical record. The oral consent provision does not apply to testing performed in correctional facilities.
- General written consent for medical care. Consent can be obtained through a signed consent for general medical care if the general consent form gives the patient an opportunity to refuse HIV testing (that is, an opportunity to opt out of being tested for HIV).
- A simple signed statement. Under the new law, a Member can provide written consent by signing a simple statement declaring that he or she consents to HIV testing. The DOH will develop model forms for obtaining written consent. However, Providers may develop their own forms based on these models.
Before being asked to consent to HIV testing, Members must be given the seven points of information about HIV required by the Public Health Law. This information can be given orally or in writing. For more information, please refer to the DOH’s website at [www.health.ny.gov/diseases/aids/testing/law/faqs.htm](http://www.health.ny.gov/diseases/aids/testing/law/faqs.htm).

**Provider Billing and Address Changes**

Prior notice to a Provider Relations representative or the WellCare Provider Services Department is required within 30 days for any of the following changes:

- 1099 mailing address
- Tax Identification Number (Tax ID or TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and fax number
- Panel changes
- Directory listing

Failure to notify WellCare prior to these changes may result in a delay in claims processing and payment. Additionally, failure to give prior notice may result in non-compliance with access and availability requirements for Members who are trying to reach Providers at addresses that are no longer valid.

**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 that 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 the Provider may be required by contract to give more notice than listed above.

- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month in which the Provider has given notice.

WellCare will notify Members of any of the following Primary Care Provider (PCP) changes:

- Members will be notified within 15 days from the date WellCare becomes aware that the Member’s PCP has changed his or her office address or telephone number.

- If a PCP ceases participation in WellCare’s network, WellCare will provide written notice within 15 days of the date that WellCare becomes aware of the change in status to each Member who has chosen the Provider as his or her PCP. In such cases, the notice shall describe the procedures for choosing an alternative PCP and, in the event that the Member is in an ongoing course of treatment, the procedures for continuing care consistent with subdivision 6 (e) of PHL § 4403.

- Where a Member’s PCP ceases participation with WellCare, WellCare will ensure that the Member selects or is assigned a new PCP within 30 days of the date of the notice to the Member.
In the event that a Member is in an ongoing course of treatment with another Provider who becomes unavailable to continue to provide services to the Member, WellCare will provide written notice to the Member within 15 days from the date WellCare becomes aware of the Provider’s unavailability to the Member. In such cases, the notice shall describe the procedures for continuing care consistent with PHL § 4403(6)(e) and for choosing an alternative Provider.

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

WellCare will notify in writing all appropriate agencies and/or Members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary Provider within the service area as required by the New York Medicaid program requirements and/or regulations and statutes.

**Out-of-Area Member Transfers**

Providers should assist WellCare in arranging and accepting the transfer of Members receiving care out of the service area if the transfer is considered medically acceptable by the WellCare Provider and the out-of-network attending physician/Provider.

**Children With Special Health Care Needs**

Children with special health care needs include those who have or are suspected of having a serious or chronic physical, developmental, behavioral or emotional condition and who require health and related services of a type or amount beyond that required by children generally.

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

- Assess Members and develop plans of care for those Members determined to need courses of treatment or regular care.
- Refer Members to WellCare’s Care Management Program.
- Coordinate treatment plans with Members, family and/or specialists caring for Members.
- Develop a plan of care that adheres 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 and Availability Standards

All PCPs are required by contract to provide access to care for Members in their panel 24 hours per day and seven days per week. Compliance with this requirement is monitored on an ongoing basis using methodology, guidelines and sample size selection formulas provided by the City of New York Office of Medicaid Managed Care (OMMC) and/or DOH. A telephone survey is conducted after hours (evening or weekends) by trained WellCare employees or a contracted vendor. Providers are expected to return the survey call within 30 minutes to be in compliance with the standard.

Obstetrical Providers are also required to be available 24 hours per day, seven days per week. The PCP, obstetrician, or designated on-call Provider should be available to coordinate services and return emergency telephone calls within 30 minutes.

WellCare shall monitor Providers against the following standards to ensure Members can obtain needed health services within the acceptable appointment timeframes, 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>Emergency – Primary or Specialty</td>
<td>Immediate upon presentation</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-Urgent “Sick”</td>
<td>Within 48-72 hours</td>
</tr>
<tr>
<td>Routine Non-Urgent or Preventative</td>
<td>Within 4 weeks of request</td>
</tr>
<tr>
<td>Specialist Referrals – Non-Urgent</td>
<td>Within 4-6 weeks of request</td>
</tr>
<tr>
<td>Adult Baseline and routine physicals</td>
<td>Within 12 weeks</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>Within 4 weeks of request</td>
</tr>
<tr>
<td>Initial Newborn Care</td>
<td>Within 2 weeks of hospital discharge</td>
</tr>
<tr>
<td>Prenatal 1st Trimester</td>
<td>Within 3 weeks of request</td>
</tr>
<tr>
<td>Prenatal 2nd Trimester</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Prenatal 3rd Trimester</td>
<td>Within 1 week of request</td>
</tr>
<tr>
<td>Initial Family Planning</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Provider visits to make health, behavioral health, substance abuse assessments for the purpose of making recommendations regarding recipient’s ability to perform work when requested by the Local Department of Social Services (LDSS)</td>
<td>Within 10 days of request</td>
</tr>
<tr>
<td>Pursuant to an emergency or hospital discharge, behavioral health or substance abuse follow up visits</td>
<td>Within 5 days of the request or as clinically indicated</td>
</tr>
<tr>
<td>Non-Urgent behavioral health or substance abuse visits</td>
<td>Within 2 weeks of request</td>
</tr>
</tbody>
</table>

Providers should not require that Members submit a copy of their medical record, complete a health screening questionnaire or meet with a social worker as a prerequisite to scheduling an appointment. These requirements may serve as barriers to accessing healthcare services. To facilitate access to care, Providers are expected to schedule the
appointment and use that opportunity to work with the Member to obtain the medical record or to complete the health screening.

In-office wait times for primary care visits, specialty and urgent care, optometry services, and lab and X-ray services shall not exceed 45 minutes.

PCPs must provide or arrange for coverage of services, consultation or approval for referrals 24 hours per day, seven days per week. To ensure accessibility and availability, PCPs must provide one of the following:

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

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

Obstetricians shall provide arrangements for emergency consultation and care for pregnant Members after hours 24 hours per day, seven days per week. To assure access and availability, one of the following must be provided:

- 24-hour answering service
- Answering system with option to page the Provider
- An advising nurse with access to the Provider or on-call physician

**Responsibilities of Primary Care Providers**

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

- Coordinate, monitor and supervise the delivery of primary care services to each Member
- See Members for an initial office visit and assessment within the first 90 days of enrollment in WellCare
- Coordinate, monitor and supervise the delivery of Medically Necessary primary and preventive care services to each Member, including EPSDT services for Members under the age of 21
- Complete a behavioral health screening on all Members
- Maintain a ratio of Members to full-time equivalent physicians as follows:
  - No more than 1,500 Members for each full-time physician or 2,400 Members for a physician practicing in combination with a registered physician assistant or a certified nurse practitioner
  - No more than 1,000 Members for each certified nurse practitioner
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infant and Children (WIC) program for nutritional assistance
- Assure Members are aware of the availability of public transportation where available
- Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or
control and either a financial relationship or a relationship for rendering services to the primary care office

- Submit an encounter to WellCare for each visit where the Provider sees the Member or the Member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service
- Submit encounters. For more information on encounters, refer to Section 5: Claims
- Identify specialist Providers within WellCare’s network when specialist services are required by the Member
- Ensure Members utilize network Providers. If unable to locate a participating WellCare Medicaid Provider for services required, contact Clinical Services for assistance. Refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid
- Comply with and participate in corrective action and performance improvement plans

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

- Support of the Provider Relations, Provider Services, Health Services, Marketing and Sales departments, as well as the tools and resources available on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid
- Information on WellCare Participating Providers for the purposes of referral management and discharge planning

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

- Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible Members in accordance with the periodicity schedule provided by the American Academy of Pediatrics (AAP)
- Referring the Member to an out-of-network Provider for treatment if the service is not available within WellCare’s network
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines
- Providing vaccinations in conjunction with EPSDT/well-child visits. Providers are required to use vaccines available without charge under the Vaccine for Children (VFC) program for Medicaid children 18 years old and younger
- Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits
- Requesting a Prior Authorization for Medically Necessary EPSDT special services in the event other health care, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the New York Medicaid Program
- Monitoring, tracking and following up with Members:
  - Who have not had a health assessment screening
  - Who miss appointments to assist them in obtaining an appointment
• Ensuring Members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with Members to ensure they receive the necessary medical services
• Assisting families with children who age-out of EPSDT services with transition to other appropriate care

For additional requirements, please see Section 3: Quality Improvement.

Closing of Physician Panel
When requesting closure of a panel to new and/or transferring WellCare Members, PCPs must:
• Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel
• Maintain the panel to all WellCare Members who were provided services before the closing of the panel
• Submit written notice of the reopening of the panel, including a specific effective date

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

Covering Providers should be credentialed by WellCare, and are required to sign an agreement accepting the negotiated rate and agreeing to not balance-bill WellCare Members. For additional information, please refer to Section 6: Credentialing.

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

Medical Residents/Fellows and Primary Care
Members have the right to request and receive care by their PCP in addition to or instead of being seen by a resident or fellow. Members must be made aware of the resident/fellow and attending PCP or specialty attending physician relationship and be informed of their rights to be cared directly by their PCP or attending specialty physician. Members must be given the name of the responsible attending PCP or specialty attending physician in writing and be told how he or she may contact the attending physician or covering physician, if needed. This allows Members to assist in the communication between their primary care Provider and specialty attending and enables them to reach the specialty attending if an emergency arises in the course of their care.

Responsibility for the care of the Member remains with the attending Provider. All attending and resident/fellow teams must provide adequate continuity of care, 24 hours per day, seven days per week coverage, and appointment and availability access.
In order for a resident/fellow to provide continuity of care to a Member, both the resident/fellow and the attending PCP must have regular hours in the continuity site and must be scheduled to be in the site together the majority of the time.

Residents/fellows may participate in the specialty care of Members in all settings supervised by fully licensed and WellCare-credentialed specialty attending physicians.

Members requiring ongoing specialty care must be cared for in a continuity of care setting. This requires the ability to make follow-up appointments with a particular resident/fellow and attending physician team, or if that Provider team is not available, with a Member of the Provider’s coverage group in order to ensure ongoing responsibility for the Member by his or her WellCare-credentialed specialist. The responsible specialist and her or his specialty coverage group must be identifiable to the Members as well as to the referring PCP.

Attending specialists must be available for emergency consultation and care during non-clinic hours. Emergency coverage may be provided by residents/fellows under adequate supervision. The attending or a Member of the attending’s coverage group must be available for telephone and/or in-person consultation when necessary.

**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 upon the Member’s medical condition, amount or variety of care required, or the cost of Covered Services required by WellCare’s Member.

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

The Provider should send supporting documentation to the WellCare Provider Services Department. Contact information is on the *Quick Reference Guide* on WellCare’s website.

**Domestic Violence and Substance Abuse Screening**

PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are located on WellCare’s website at [www.wellcare.com/New-York/Providers/Clinical-Guidelines/CCGs](http://www.wellcare.com/New-York/Providers/Clinical-Guidelines/CCGs). If a Member needs assistance regarding domestic violence or substance abuse, the Provider should direct the Member to contact the WellCare Customer Service Department.
Department and ask to speak with the Care Management Department. For more information, refer to the *Quick Reference Guide* on WellCare’s website.

**Smoking Cessation**

Tobacco has been linked to lung cancer and other deadly chronic diseases such as diabetes. WellCare urges Providers to help Members fight tobacco addiction as part of their standard of care rendered to their Members. For every Member at every clinic visit, the healthcare Provider should:

- Identify whether a Member is a smoker
- Document smoker status in the Member’s chart as a vital sign as well as send the appropriate dx code on the claim
- Fill out WellCare’s Tobacco Dependence Treatment Record at [www.wellcare.com/New-York/Providers/Medicaid/Forms](http://www.wellcare.com/New-York/Providers/Medicaid/Forms)
  - Treat by introducing pharmacological counseling therapies
  - Provide smoking cessation resources, such as:
    - NY State Smoker’s Quitline – 1-866-NY-QUITs or 1-866-697-8487
    - Smoking Cessation Centers – for a list of smoking cessation centers in NYC and Long Island, [www.nysmokefree.com](http://www.nysmokefree.com)

**Adult Health Screening**

An adult health screening should be performed by a Provider to assess the health status of all WellCare Medicaid 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/New-York/Providers/Clinical-Guidelines/CCGs](http://www.wellcare.com/New-York/Providers/Clinical-Guidelines/CCGs).

For assistance with the CMS Star measure of Care of Older Adults, WellCare has created the Care of Older Adults Assessment Form found at [www.wellcare.com/New-York/Providers/Medicaid/Quality](http://www.wellcare.com/New-York/Providers/Medicaid/Quality).

**Vision Services**

WellCare will allow its Members to self-refer to any participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services and, for Members diagnosed with diabetes, for an annual dilated eye (retinal) examination.

**Diagnosis and Treatment of Tuberculosis**

Members may self-refer to public health agency facilities for the diagnosis and/or treatment of tuberculosis (TB).

**Tuberculosis Control Directly Observed Therapy**

The New York City Department of Health and Mental Hygiene (NYCDOHMH) provides specialized care to patients who have suspected or confirmed tuberculosis, including tuberculin skin testing, outpatient medical and nursing services, home nursing services and directly observed therapy (DOT). DOT is now accepted as the standard of care for patients with tuberculosis and entails having a trained health care worker observe the patient take prescribed anti-TB medications. DOT services can be provided in Chest Centers, at patient’s homes, places of work or other community sites. Patients enrolled in the program are more likely to complete their tuberculosis treatment and less likely to relapse.
Although TB/DOT is a Non-Covered service, WellCare is responsible for communicating, cooperating and coordinating clinical management of tuberculosis with the TB/DOT Provider. Providers are required to report to the NYC DOMH or the Local Public Health Administration as well as inform WellCare when a Member is diagnosed with tuberculosis.

**Primary and Preventive Obstetric and Gynecologic Care**

WellCare shall not limit a female Member’s direct access to primary and preventive obstetric and gynecologic services from a qualified participating Provider of such services of her choice to less than two examinations annually for such services or to any care related to a pregnancy. In addition, WellCare will not limit direct access to primary and preventive obstetric and gynecologic services required as a result of annual examinations or as a result of an acute gynecologic condition, provided that the qualified Provider is a Participating Provider and discusses the services and treatment plan with the Member’s PCP in accordance with the requirements of WellCare. WellCare will notify, in writing, each female Member of the availability of these services, as described.

**Obstetrical/Gynecological Provider Responsibilities**

**Family Planning**

Family Planning and reproductive health services are free-access services that do not require a referral from a Primary Care Provider. Members may obtain family planning and reproductive health services, HIV blood testing and pre- and post-test counseling from WellCare Providers or from any appropriate Medicaid Provider. Family planning and reproductive health services include these Medically Necessary procedures (and related drugs/supplies), administered by a Provider or certified nurse practitioner during the course of a family planning visit:

- Contraception, including insertion/removal of an IUD, insertion/removal of Norplant and injection procedures involving pharmaceuticals such as Depo-Provera
- Sterilization
- Screening, related diagnosis and referral to participating Provider for pregnancy
- Medically Necessary induced abortions and for New York City recipients, elective induced abortions (authorization required)

**Prenatal and Post-Partum Care**

Prenatal care will be provided in accordance with generally accepted standards of practice and services rendered in accordance with Subdivision 1, Section 2522 of the Public Health Law Part 85.40, Prenatal Care Assistance Program (PCAP).

In order to ensure continuity of care and early identification of the need for care management services, please notify WellCare of pregnant Members at the initial prenatal care visit. WellCare’s *Prenatal Notification* form is located on WellCare’s website at [www.wellcare.com/New-York/Providers/Medicaid/Forms](http://www.wellcare.com/New-York/Providers/Medicaid/Forms). A centralized prenatal care record will be established that documents the provision of care and services and that will include, but not be limited to, the following:

- Initial screening
- Risk assessment
- Individualized care plan
- Psychosocial assessment
- Nutritional assessment
- Prenatal diagnostic and treatment services

Post-partum care should be provided approximately 4-6 weeks after delivery.

Women with a complicated gestation or delivery by cesarean section should have a visit scheduled within 7-14 days of delivery. The visit should include an interval history and a physical examination to evaluate the patient’s current status and adaptation to the newborn.

PCAP standards require the following HIV services:
- Provide all pregnant women with HIV counseling and education as early as possible without regard to risk
- Offer pregnant women confidential HIV testing
- Mandatory testing during the first and third trimester (34-36 weeks) for all pregnant persons who tested negative in the first trimester. Counseling and consent for both test can be done at initial test. The pregnant woman should be informed that if she does not have a prenatal test, she will be HIV-counseled again when she presents for delivery, and that expedited testing will be done on her, with her consent, or on the newborn, without her consent. She should also be told that all newborns are routinely screened for HIV as part of the Newborn Screening Program, as a final safety net to identify exposed infants.
- Provide the HIV positive woman and her newborn infant the following services or make the necessary referrals for these services
  - Management of HIV disease; Coordination with HIV specialist who are familiar with caring for HIV positive pregnant women
  - Psychosocial support
  - Care management to assist in coordination of necessary medical, social and addictive services


**Hospital / Facility Responsibilities**
Coverage is provided for eligible Members for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Care must be rendered under the direction of a doctor or by an institution that is licensed or formally approved as a hospital by an officially designated state standard-setting authority. The Provider must be qualified to participate under Title XIX (Medicaid) of the Social Security Act.

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

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

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

However, some patients may require 48 hours of outpatient observation services. Refer to the *Section 4: Utilization Management, Care Management, and Disease Management* for more information.

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

Hospital-based clinics, which are operated as part of a hospital, are considered outpatient hospital-based facilities by WellCare. As such, these facilities must follow authorization rules for hospital-based services. Refer to the *Section 4: Utilization Management, Care Management, and Disease Management* for more information.

Level of care determinations will be based on InterQual™ criteria and the review of a WellCare medical director. Effective March 4, 2019, level of care determinations will be based on Milliman Clinical Guidelines (MCG) criteria and the review of a WellCare medical director.

**Cultural Competency Program and Plan**

The purpose of the Cultural Competency program is to ensure that WellCare meets the unique diverse needs of all Members, to ensure that the associates of WellCare value diversity within the organization, and to see that Members in need of linguistic services receive adequate communication support. In addition, WellCare is committed to having Providers fully recognize and care for the culturally diverse needs of the Members they serve. Providers must adhere to the Cultural Competency Program described in this section.

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

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Use culturally sensitive and appropriate educational materials based on the Member’s race, ethnicity, and primary language spoken

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

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

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

Decrease health care disparities in the minority populations WellCare serves

Culturally and Linguistically Appropriate Services (CLAS) are health care services provided that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent health care and services requires that health care Providers and/or their staff 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:** WellCare analyzes data on the populations in each region it serves for the purpose of learning about that region’s cultural and linguistic needs, as well as any health disparities specific to that region. Such analyses are performed at the time WellCare enters a new market and regularly thereafter, depending on the frequency with which new data become available. Data sources and analysis methods include the following:
  - State-supplied data for Medicaid and CHIP populations
  - Demographic data available from the U.S. Census and any special studies done locally
  - Claims and encounter data to identify the health care needs of the population by identifying the diagnostic categories that are the most prevalent
  - Member requests for assistance, or Member grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle
  - Data on race, ethnicity and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers

- **Community-Based Support:** Our success requires linking with other groups that share the same goals.
  - WellCare reaches out to community-based organizations that support racial and ethnic minorities, and the disabled, to ensure that existing community resources for Members who have special needs are used to their full potential. The goal is to coordinate the deployment of both community and health plan resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.
  - WellCare develops and maintains grassroots sponsorships that enhance our effort to reach low-income communities. WellCare also provides opportunities for building meaningful relationships that benefit all Members of the communities. These sponsorships are coordinated with Providers, community health fairs and public events.
• Diversity and Language Abilities of WellCare: WellCare recruits diverse talented staff to work in all levels of the organization. WellCare does not discriminate with regard to race, national origin, sex, age, disability, religion or ethnic background when hiring staff.
  o WellCare ensures that bilingual staff members are hired for functional units that have direct contact with Members to meet the needs identified. Today, one-third of WellCare’s Customer Service representatives are bilingual. Spanish is the most common translation required. Whenever possible, WellCare will also distinguish place of origin of its Spanish-speaking staff, to ensure sensitivity to differences in cultural backgrounds, language idioms and accents. For example, in New York City, the Puerto Rican population is predominant.
  o Where WellCare enrolls significant numbers of Members who speak languages other than English or Spanish, WellCare seeks to recruit staff members who are bilingual in English plus one of those other languages. WellCare does this even if the particular population is not of a size that triggers state agency mandates.

• Diversity of Provider Network
  o Providers are inventoried for their language abilities. This information is made available in the Provider Directory so that Members can choose a Provider that speaks their primary language.
  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 are provided by vendors with such expertise and 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/TDD 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/TDD number can be found on the Member identification card.

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

For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on WellCare’s website. A paper
Providers may access the Cultural Competency Survey on WellCare’s website at www.wellcare.com/en/New-York/Providers/Medicaid/Quality.

Member Administrative Guidelines

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

Member Handbook
WellCare will mail all enrolled Members a Member Handbook. Newly enrolled Members will receive a Member Handbook within 14 days of the effective date of enrollment.

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

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

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

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

Providers may do one of the following to verify eligibility:
- Access the secure, online Provider Portal of the WellCare website
- Access WellCare’s interactive voice response (IVR) system
- Contact the WellCare 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, both adults and children, have specific rights and responsibilities. These are included in the *Member Handbook.*

WellCare Members have the right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation
- Be treated with respect and with due consideration for their dignity and privacy
- Be told where, when and how to get the services needed from WellCare
- Be told by the PCP what is wrong, what can be done for them, and what will likely be the result in language understood by them
- Get a second opinion about their care
- Give their consent to any treatment or plan for their care after that plan has been fully explained to them
- Refuse care and be told what they may risk if they do
- Get a copy of their medical record, and talk about it with their PCP. Members can ask that their medical record be amended or corrected, if needed
- Be sure that the medical record is private and will not be shared with anyone except as required by law, contract, or their consent
- Use WellCare’s complaint system to settle any complaints. Members can complain to the DOH or the local Department of Social Services any time they feel they were not fairly treated
- Use the State Fair Hearing system
- Appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves regarding their care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints
- A right to receive information about WellCare, its services, its practitioners and Providers, and Members rights and responsibilities
- A right to participate with practitioners in making decisions about their health care
- A right to a candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage
- Make complaints or appeals about WellCare or the care provided by its network of Providers, and to know that if they do, it will not affect how they are treated
- A right to make recommendations regarding the organization’s Member rights and responsibilities policy
- 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, 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)
• 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

WellCare Members also have certain responsibilities. These include the responsibility to:
• Work with their PCP to guard and improve their health
• Find out how the health care system works
• Listen to the PCP’s advice and ask questions when they are in doubt
• Call or go back to the PCP if they do not get better, or ask for a second opinion
• Treat health care staff with respect
• Tell WellCare if they have problems with any health care staff
• Keep their appointments. If they must be canceled, Members should call as soon as they can
• Use the emergency room only for true emergencies
• Call the PCP when they need medical care, even if it is after hours
• Supply information (to the extent possible) that WellCare and its Providers need in order to provide care
• Follow plans and instructions for care that they have agreed to with their Providers
• Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
• 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
• 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 Member Handbook
• Inform WellCare if they move
• Inform WellCare of any questions, concerns, problems or suggestions by calling the WellCare Customer Service Department telephone number listed in their Member Handbook

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

If a Member does not select a PCP, WellCare will assign the Member a PCP within 30 days after WellCare is notified of enrollment. WellCare will notify the Member of the assignment. PCP assignments are based on the Member’s geographic location, any known special health care needs, and any known language needs.

**Changing Primary Care Physicians**

Members may change their PCP selection at any time by calling the WellCare Customer Service Department.

WellCare will process a request to change PCPs and advise the Member of the effective date of the change within 30 days of receipt of the request. The change will be effective no later than the first day of the second month following the month in which the request is made.

Members have an opportunity to select a new PCP when the Member’s current PCP leaves the network or otherwise becomes unavailable. Such a change will not be considered in the calculation of changes for cause allowed within a six month period. WellCare may assign a Member a new PCP when the Member fails to choose a PCP under the following circumstances:

- The Member requires specialized care for an acute or chronic condition and the Member and WellCare agree that reassignment to a different PCP is in the Member’s interest
- The Member’s place of residence has changed such that he or she has moved beyond the PCP travel time/distance standard
- The Member’s PCP ceases to participate in the WellCare network
- The Member’s behavior toward the PCP is disruptive and the PCP has made all reasonable efforts to accommodate the Member
- The Member has taken legal action against the PCP or the PCP has taken legal action against the Member

**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 the WellCare Customer Service Department. PCPs should coordinate these services for WellCare Members and contact Customer Service if assistance is needed. For the WellCare Provider Services Department telephone numbers, please refer to the *Quick Reference Guide* on WellCare’s website.
Section 3: Quality Improvement

Overview
WellCare’s Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities are implemented in response to findings. 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:

- Quantitative and qualitative improvement in Member outcomes
- Coordination and continuity of care with seamless transitions across health care settings/services
- Cultural competency
- Credentialing
- Quality of care/service
- Patient Safety and Confidentiality
- Preventative health
- Service utilization
- Complaints/grievances
- Appeals
- Adverse Events
- Network adequacy
- Disease and Care Management
- Behavioral Health Services
- Member and Provider satisfaction
- Components of operational service
- Regulatory/federal/state/accreditation requirements
- Appropriate service utilization

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and/or medical record audits. The organization’s Board of Directors has delegated authority to the Quality Improvement Committee to approve specific QI activities (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

The goals of the QI Program are to:

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

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

The following are Quality Improvement activities performed by WellCare on an ongoing
basis:
• Preventive health maintenance
• Development and review of Clinical Practice Guidelines
• Disease Management initiatives
• HEDIS® studies
• State QI projects
• Referrals for quality issues
• Provider-specific issues identified through tracking and trending of complaints or
  referrals
• Medical record content reviews – please review the Medical Records section
  below for specific documentation standards and requirements
• Chronic care improvement programs

Provider Participation in the Quality Improvement Program
Providers are contractually required to comply with quality improvement activities, such
as HEDIS activities and medical records reviews.

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

Member Satisfaction
The Centers for Medicare & Medicaid Services (CMS) develops, implements and
administers several different Member surveys. These surveys ask Members (or in some
cases their families) about their experiences with, and ratings of, their health care
Providers and plans, including hospitals, home health care agencies, doctors, and health
and drug plans. CMS publicly reports the results of its patient experience surveys, and
some surveys affect payments to Medicaid Providers.

Patient experience surveys focus on asking patients whether or how often they
experienced critical aspects of health care, including communication with their doctors,
understanding their medication instructions, and the coordination of their healthcare needs.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are developed by CMS and are designed to reliably assess the experiences of a large sample of Members. They use standardized questions and data collection protocols to ensure that information can be compared across healthcare settings. The quality of services is measured clinically, administratively, and through the use of Member experience of care surveys. CMS publicly reports aggregate results for participating MA contracts and beneficiaries use results to compare health plans.

**Provider Performance Appraisal**

Quality of care data is linked to the re-credentialing process. Information is supplied as requested to ensure evaluations are based on the most current data. The Quality Improvement Department is responsible for collection, maintenance and distribution of information via Provider Performance Appraisal forms, which include the following:

<table>
<thead>
<tr>
<th>Area of Concern</th>
<th>PCP&gt;50 Members</th>
<th>PCP&lt;50 Members</th>
<th>Specialists</th>
<th>Source of Information/ Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility Availability</td>
<td>X</td>
<td>X</td>
<td>As available</td>
<td>• Complaints</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Provider</td>
</tr>
<tr>
<td>Under- or Over-Utilization</td>
<td>As available</td>
<td>As available</td>
<td>As available</td>
<td>• PCP encounter rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Utilization data</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• QI health improvement data</td>
</tr>
<tr>
<td>Risk Management, Ambulatory Sensitive Conditions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>• Incident Reporting</td>
</tr>
<tr>
<td>Sentinel Events</td>
<td></td>
<td></td>
<td></td>
<td>• UM Data</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Any QI issues/level of concern after resolution</td>
</tr>
<tr>
<td>Member Satisfaction</td>
<td>As available</td>
<td>N/A</td>
<td>N/A</td>
<td>Use complaints rate as proxy</td>
</tr>
<tr>
<td>Site Reviews</td>
<td>X</td>
<td>X</td>
<td>As available</td>
<td>Medical Record/Site Review Database</td>
</tr>
<tr>
<td>Member Complaints</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Complaint Database</td>
</tr>
</tbody>
</table>

Well-documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality care. In private office or clinic settings, the medical record is an essential tool for communication between Providers.

All Providers rendering healthcare services to WellCare Members must maintain a Member health record in accordance with standards in compliance with National Committee for Quality Assurance (NCQA®) Guidelines for Medical Record Review (Appendix V) and NYSDOH regulations. Further, Providers should be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical record information with other network Providers.
Periodically, WellCare requests medical records and conducts reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. In many instances, such reviews are required under the Medicaid or CHPlus programs. All medical record reviews are conducted by clinical professionals, and all information contained in the records is kept strictly confidential. Providers must make medical records available upon request by WellCare or by CMS, NYSDOH, or any other regulatory agency with jurisdiction over Medicaid or CHPlus programs.

The provision of enrollee personal health information and records for the purposes listed below constitute healthcare operations pursuant to 45 CFR 501, and therefore the Member’s explicit consent is not required for the release of such records and information to WellCare. However, the Member’s authorization to allow WellCare to review records is also obtained by WellCare at the time of the Member’s enrollment in the plan.

WellCare reviews medical records as part of the following activities:

- Recredentialing
- Clinical quality of care investigations
- Monitoring utilization to validate prospective and concurrent review processes, identify trends, assess level of care determinations, and review billing issues
- Monitoring for accuracy and completeness of coding
- Monitoring for compliance with approved Practice Guidelines and Standards of Care
- Reporting for Quality Improvement and Peer Review Organization studies and HEDIS®/QARR measure compliance
- Monitoring of Provider compliance with public health regulations on reporting requirements
- Monitoring for compliance with Ambulatory Medical Record Review (AMRR) Documentation Standards

In addition, NYSDOH and Peer Review Organizations audit medical records as part of their respective quality review processes. If deficiencies are found after an internal medical record review or a review conducted by regulatory agencies, Providers will be required to participate in a corrective action plan, as necessary.

Medical records must be maintained by practitioners who are providing primary care and referral services. They must be maintained for a period of six years after the last visit date or, in the case of minors, for six years from the age of majority for New York State programs (Healthy Choice Members) and 10 years for New York State of Health (NYSOH) Members.

WellCare, in accordance with state and federal contracts and regulations, will facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under- and overutilization of services.

The process may include implementation of a corrective action plan for the Provider and WellCare.

The following tools will be utilized for monitoring:

- Inpatient daily census
- Monthly inpatient utilization reports
Funding reports
Pharmacy reports
Physician profiling
Care management

WellCare’s Utilization Management Department monitors the inpatient daily census report for all non-participating Providers, hospital stays for outliers, and quality of care issues. These include all readmissions, any complications, and/or unexpected deaths. The medical director communicates with the concurrent review staff regarding any of these issues. He or she will contact the PCP for any issues arising out of the review.

A WellCare medical director, or designee, reviews the following data:

- Pharmacy Data: A monthly report is generated, demonstrating monthly per Member per month for prescription drug and injectable drug utilization and cost per line of business. The medical director will compare the report results to local and national standards and develop a corrective action plan as needed.
- Ancillary service utilization data will be pulled monthly with the following filters:
  - Home health referrals and cost per Member per month per line of business
  - DME per Member per month and cost per Member per month per line of business
- Lab services utilization per Member per month and cost per Member per month per line of business.
- Physician Profiling: The physician profiling reports will be monitored on a quarterly basis for a designated Provider population. The report generated will contain the following:
  - Efficiency index
  - Episodic Treatment Group Report
  - HEDIS measurements
  - Ancillary service utilization
  - Inpatient services utilization
  - Pharmacy utilization

A medical director will compare WellCare’s results to industry standards and develop a corrective action plan as needed.

WellCare will provide any information and profiling data used to evaluate the Provider’s performance and shall make available on a periodic basis and upon request of the healthcare professional the information, profiling data and analysis used to evaluate Provider performance.

Any issues arising out of these reports are discussed with the PCP by the Medical Director on an as-needed basis, or in a meeting coordinated with the Provider Relations Department.

Over- and underutilization data and reports are reported at the Medical Management Committee for review and recommendations. The recommendations and results are then communicated to the Quality Improvement Council and then to the Board of Directors.
Each Provider is given the opportunity to discuss the unique nature of the Provider’s professional patient population, which may have bearing on the Provider’s profile, and to work cooperatively with WellCare to improve performance.

**EPSDT Screen Periodicity Schedule**

A Member should have an initial health check screening:
- Within 90 days of enrolling in WellCare or upon change to a new PCP, if prior medical records do not indicate current compliance with the periodicity schedule
- Within 24 hours of birth for newborns

A well-child visit should be conducted at birth (neo-natal examination), and at minimum at 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months and once a year for ages 2 to 20 years. The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5.

The medical record must contain documentation of a comprehensive health history in addition to an unclothed physical examination to determine if the child’s development is within the normal range for the child’s age and health history.

Each Provider office is required to have the following equipment to provide a complete health check:
- Weight scale for infants
- Weight scale for children and adolescents
- Measuring board or device for measuring length or height in the recumbent position for infants and children up to age 2
- Measuring board or device for measuring height in the vertical position for children who are 2 years old or older
- Blood pressure apparatus with infant, child and adult cuffs
- Screening audiometer
- Centrifuge or other device for measuring hematocrit or hemoglobin
- Eye charts appropriate to children by age
- Developmental and behavioral screening tools
- Ophthalmoscope and otoscope

Requirements of EPSDT screens include the following:
- Immunizations are administered at required age parameters and intervals with dates documented. If the immunizations are not up-to-date according to age and health history, the Provider should document why immunizations were not given at the time of the EPSDT screen. For the immunization schedule, refer to the preventive pediatric health care guidelines for children located on WellCare’s website. Note that certain immunizations may not be covered in the context of covered benefits.

The purpose of the Childhood Immunization measure is to assess the immunization levels of children aged two for the provision of the following antigens:
o Four diphtheria/tetanus/pertussis containing vaccines
o Three polio vaccines
o One measles/mumps/rubella (MMR) vaccine
o At least three H Influenza type B vaccines
o Three hepatitis B vaccines
o One varicella vaccine
o At least four pneumococcal conjugate vaccines
o At least one hepatitis A vaccine
o At least two doses of the two-dose rotavirus or three doses of the three-dose rotavirus vaccine
o At least two influenza vaccines

Individual antigen information collected from plans allows for the flexibility of reporting Combo 10 immunization rates as well as specific rates of compliance. A PCP is responsible to perform all required components of an EPSDT health screen, as per the AAP and ACIP periodicity schedules, and document appropriately in the Member’s medical record. If a PCP chooses not to provide the immunization component of the screen, she or he is accountable to refer the Member to another network Provider (such as a health department entity) who can provide this service in a timely manner. WellCare expects the PCP to follow up with the referred Provider to obtain documentation regarding the provision of the immunization(s) in order to maintain an accurate and complete medical record. WellCare will monitor for compliance to these requirements by reviewing immunization rates by PCP. In the event the immunization rate of the PCP is less than the network average, WellCare will assess for practice access and availability by:

- Conducting an audit to verify compliance with access and availability
- Requiring adoption of a corrective action plan if access and availability standards are not met
- Performing a focused medical record review. In the event of negative findings, a corrective action plan will be requested:
  - If compliance to the corrective action plan is not demonstrated, WellCare will assess for a fee reduction
  - If lack of compliance continues, WellCare will petition for removal from network participation

- Annual TB skin testing is required if the Member is in a high-risk category. Only those children locally identified at high-risk for TB disease should be tested. Results of TB risk assessment and testing as needed should be documented in the child’s medical record.
- Developmental delay is to be assessed by use of a formalized tool at 9 and 18 months and at 2 and 3 years.
- Well-child visits should be conducted and documented. The C/THP specifies that infants from birth to 12 months of life should have received six wellness/preventive visits. The C/THP recommends one wellness visit each year at the ages of 4, 5 and 6. Members 3 to 6 years old should be screened for BMI, Physical Activity Counseling and Nutritional Counseling.
- Lead Poisoning Prevention/Screening: New York State Lead Screening and Follow-up Regulations require pediatric health care Providers to:
  - Test 1- and 2-year-olds for blood lead levels as part of well-child care
- Assess other children 6 months to 6 years of age for risk of high dose exposure
- Test every child found through risk assessment to be at risk for lead exposure and any Medicaid enrollee from 36 to 72 months who has not been previously tested
- Provide parents with written documentation of blood lead testing
- Report all blood lead levels equal to 10μg/dL to the NYC Department of Health and Mental Hygiene within 24 hours (Providers using portable blood lead analyzers must report all test results.)
- Provide appropriate medical management including follow-up blood lead testing, developmental surveillance and risk reduction education for children found to have blood lead levels is equal to 10μg/dL.

- Well-care visits for adolescents and young adult (ages 12 to 21 years) should be conducted. Members, aged 12 to 21, should have at least one well-care visit with a PCP each year. Members aged 12 to 21 should be screened for BMI, Physical Activity Counseling, Nutritional Counseling, Substance Abuse, Depression, Tobacco and Sexual Activity.
- Use of appropriate medications should be provided to children ages 5 to 17 years with persistent asthma to control their condition.
- An annual dental visit should be conducted for children and adolescents ages 2 to 21 years. A documented dental screening, including an assessment of dental status, and the findings and/or recommendations must be documented in the medical record. The Provider must recommend children who are 3 years and older (or a younger child if Medically Necessary) for an assessment by a dentist and document this referral in the child’s medical record. Documentation of recommendation to see a dentist is sufficient.
- Documented vision screening, including an assessment of vision status, and the findings are documented in the medical record at each well-child visit. This includes age-appropriate testing to determine if the child’s vision is within the normal range.
- Appropriate treatment for upper respiratory infection should be provided for children ages 3 months to 18 years, who were diagnosed with an upper respiratory infection (common cold).
- Appropriate testing for pharyngitis: The purpose of this measure is to determine the percentage of children, ages 2 to 18 years, who were diagnosed with pharyngitis, were prescribed an antibiotic, and who were given a group A streptococcus test.
- Adolescent Preventive Care Measures: The purpose of this measure is to determine the percentage of children, ages 14 to 18 years, who received six components of preventive care during well-care visits. These components include body mass index (BMI), nutrition and physical activity, sexual activity, depression, tobacco use and substance use.
- Adolescent Health Screening should be conducted on Members ages zero to 20 years. The purpose of the Child/Teen Health Checkup is to provide comprehensive, preventive, well-child care on a regularly scheduled basis for identification and correction of medical conditions before the conditions become serious and disabling, and as an entry into the health care system and, for access to a medical home. Age-appropriate Child Health Check-Up Tracking forms are available on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid/Forms.
• A WIC referral must be completed. A referral for all pregnant, breastfeeding, and postpartum women, infants and children up to age 5 will be made to the WIC program.

• Documentation of a nutritional assessment, including nutritional status, with findings must be documented in the medical record at each well-child visit. This includes height and weight (measured and plotted on standard chart), head circumference if 24 months or younger, dietary intake, eating habits, and use of alcohol, drugs or tobacco. Evaluation is suggested for the following groups:
  o Children who demonstrate weight loss or no gain over a period of time
  o Children who are overweight in proportion to their height (greater than 95th percentile, weight for height variation from expected growth parameters, height below 5th percentile)
  o Presence of diseases in which nutrition plays a key role (such as cardiovascular disease, hyperlipidemia, Gl disorders, hypertension, metabolic disorders, physical and mental handicaps affecting feeding, allergies, surgery and burns)

• Anemia screening with a report of the Hemoglobin and Hematocrit (H&H) must be in the record. H&H is recommended at the following ages with results documented in the child’s medical record:
  o 9 months
  o 15 months (recommended for children at risk)
  o 13 years
  o All menstruating adolescents should be screened annually
  o When medically indicated

• A urinalysis should be completed if indicated. Urinalysis is recommended for children at age 5 and 16 and as indicated. Performing urine dipstick urinalysis for leukocytes is recommended annually for sexually active male and female adolescents.

• Serum cholesterol screening should be conducted if indicated. Serum-cholesterol determination testing is recommended in children with a family history of familial hyperlipidemia.

• Age-appropriate anticipatory guidance, or health education and counseling, should be provided to the parent, guardian, and/or child, at each well-child visit.

• Family planning services or counseling should be offered to appropriate Members. WellCare makes available and encourages all pregnant women and mothers to receive, and provide documentation in the medical records to reflect counseling and services for family planning to all women and their partners.

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

Additional responsibilities of EPSDT Providers include:

• Educate pregnant women and families with children and young adults under age 21 about the program and its importance to their health

• Educate network Providers about the program and what their responsibilities are
• Conduct outreach activities, including by mail, telephone and through home visits where appropriate, to ensure children are kept current with respect to their periodicity schedules
• Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals and conduct follow-up with children and adolescents who miss or cancel appointments
• Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen
• Achieve and maintain an acceptable compliance rate for screening schedules during the contract period

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

For more information on EPSDT Covered Services, refer to Section 1: About WellCare. For more information on the periodicity schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at www.aap.org/en-us/Documents/periodicity_schedule.pdf.

Clinical Practice Guidelines
WellCare adopts validated evidence-based Clinical Practice Guidelines and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede Clinical Practice Guidelines, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations. The Clinical Practice Guidelines are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the Clinical Practice Guidelines occurs through the Quality Improvement Committee. Clinical Practice Guidelines, to include preventative health guidelines, are on WellCare’s website at www.wellcare.com/New-York/Providers/Clinical-Guidelines/CPGs.

Quality Assurance Reporting Requirements
New York State Quality Assurance Reporting Requirement (QARR) consists of measures from the National Committee for Quality Assurance’s (NCQA®) Healthcare Effectiveness Data and Information Set (HEDIS®) and New York State-specific measures. QARR incorporates measures from HEDIS. The major areas of performance included in the QARR are:
1) Effectiveness of care
2) Access to/availability of care
3) Satisfaction with the experience of care
4) Use of services
5) Health plan descriptive information
6) NYS-specific measures (Adolescent Preventive Care, Viral Load Suppression, and Prenatal Care measures from the Live Birth file)

HEDIS is a mandatory process that occurs annually. The results of WellCare’s compliance with the measures are reported annually to the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and
the State of New York. Providers can request a copy of the results. The HEDIS process is an opportunity for WellCare and its Providers to demonstrate the quality and consistency of care that is available to Members. Medical records and claims data are reviewed to ensure the required data are captured. Compliance with HEDIS standards is reported on an annual basis with results available to Providers upon request. Through compliance with HEDIS standards, Members benefit from the quality and effectiveness of care received and Providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

Below are the measures included in HEDIS

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>MEASURES</th>
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<tbody>
<tr>
<td>Effectiveness of Care</td>
<td>• Adult BMI assessment</td>
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<tr>
<td></td>
<td>• Weight assessment and counseling for nutrition and physical activity for children/adolescents</td>
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<td></td>
<td>• Childhood immunization status</td>
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<td>• Immunizations for adolescents</td>
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<td>• Lead screening in children</td>
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<td>• Breast cancer screening</td>
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<td>• Cervical cancer screening</td>
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<td>• Chlamydia screening in women</td>
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<td>• Colorectal cancer screening</td>
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<td>• Appropriate testing for children with pharyngitis</td>
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<td></td>
<td>• Appropriate testing for children with upper respiratory infection</td>
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<td></td>
<td>• Avoidance of antibiotic treatment in adults with acute bronchitis</td>
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<td></td>
<td>• Use of spirometry testing in the assessment &amp; diagnosis of COPD</td>
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<tr>
<td></td>
<td>• Pharmacotherapy management of COPD exacerbation</td>
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<td></td>
<td>• Use of appropriate medications for Members with asthma</td>
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<td></td>
<td>• Asthma medication ratio</td>
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<td></td>
<td>• Medication management for Members with asthma</td>
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<td></td>
<td>• Controlling high blood pressure</td>
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<td>• Persistence of beta-blocker treatment after a heart attack</td>
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<td>• Statin therapy for patients with cardiovascular disease</td>
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<td></td>
<td>• Statin therapy for patients with diabetes</td>
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<td></td>
<td>• Comprehensive diabetes care</td>
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<td></td>
<td>• Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis</td>
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<td>• Use of imaging studies for low back pain</td>
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<td></td>
<td>• Antidepressant medication management</td>
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<td>• Follow-up care for children prescribed ADHD medication</td>
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<td>• Follow-up after hospitalization for mental illness</td>
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<td></td>
<td>• Annual monitoring for Members on persistent medications</td>
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<td></td>
<td>• Medical assistance with smoking and tobacco use cessation</td>
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<td></td>
<td>• Follow-up after emergency department visit for mental illness</td>
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<tr>
<td></td>
<td>• Follow-up after emergency department visit for alcohol and other drug dependence</td>
</tr>
<tr>
<td></td>
<td>• Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications</td>
</tr>
<tr>
<td></td>
<td>• Diabetes monitoring for people with diabetes and schizophrenia</td>
</tr>
<tr>
<td></td>
<td>• Metabolic monitoring for children and adolescents on antipsychotics</td>
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<tr>
<td></td>
<td>• Use of first-line psychosocial care for children and adolescents on antipsychotics</td>
</tr>
</tbody>
</table>
Access & Availability of Care
- Adults’ access to preventive/ambulatory health services
- Children and adolescents’ access to primary care practitioners
- Prenatal and postpartum care
- Annual dental visit
- Initiation and engagement of alcohol and other drug dependence treatment
- Call answer timeliness
- Call abandonment

Experience of Care
- CAHPS® health plan survey adult version
- CAHPS health plan survey child version
- Children with chronic conditions

Utilization & Relative Resource Use
- Frequency of ongoing prenatal care
- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, fifth, and sixth years of life
- Adolescent well-care visits
- Frequency of selected procedures
- Ambulatory care
- Inpatient utilization – general hospital/acute care
- Identification of alcohol and other drug services
- Mental health utilization
- Plan all-cause readmissions
- Antibiotic utilization
- Inpatient hospital utilization
- Emergency Department utilization
- Hospitalization for potentially preventable complications
- Standardized health care-associated infection ratio

Special Needs Program Reporting
In addition to the standard reporting requirements, Members enrolled in the Special Needs Plans at WellCare are also required to meet the following requirements.

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>MEASURE/DESCRIPTION</th>
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<tbody>
<tr>
<td>Advance Care Planning</td>
<td>Evidence of discussion of advance care planning, advance directives, and/or healthcare proxy</td>
</tr>
<tr>
<td>Medication Review</td>
<td>At least one documented review of all medications and the presence of a medication list in the medical record</td>
</tr>
<tr>
<td>Functional Status Assessment</td>
<td>Documentation in the record of at least one complete functional assessment every year</td>
</tr>
<tr>
<td>Pain Screening</td>
<td>At least one pain screening or pain management plan every year. Screening must be complete and not related only to one area of the body</td>
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</table>

Ambulatory Medical Record Review (AMRR)
New York State Regulatory requires WellCare to conduct an Ambulatory Medical Record Review (AMRR) annually on a randomly selected number of Provider charts to ensure compliance with clinical practice guidelines and medical record documentation guidelines. A passing mark for providers is 80 percent. Providers scoring below 80 percent will be placed on a corrective action plan and re-audited in one year. WellCare staff will work with Providers on action plans to ensure they become compliant with clinical practice and medical record documentation guidelines.
Medical Records
Medical records should be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secure, legible, current, detailed and organized manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Complete medical records include, but are not limited to:

- Signature and date
- 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

Confidentiality of Member information must be maintained at all times. Records are to be stored securely for a period of six years after the date of service and for minors, for a period of three years after majority or for six years after the date of service, whichever comes later. Access should be granted to authorized-personnel only. Access to records should be granted to WellCare, its representatives, the IPA, or DOH without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. WellCare follows State and Federal law regarding the retention of records remaining under the care, custody and control of the physician or health care Provider. For information regarding confidentiality of Member information and release of records, refer to Section 8: Compliance.

To comply with regulatory and accreditation requirements, the Quality Improvement Department may conduct annual medical record audits in Provider offices. A Member’s record will be reviewed for content and evidence that care and screenings have been documented, as applicable. Providers will be given results at the time of the audit, and a corrective action plan will be required if the score is not higher than 80 percent. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

The goals of conducting medical record reviews include enabling WellCare to assess the level of Provider compliance to documentation standards and clinical guidelines (disease and preventive) and to gauge quality of care and patient safety practices.

Medical Records Documentation Requirements
Each Provider is required to maintain a primary medical record for each Member. The medical record must contain sufficient medical information from all Providers involved in the Member’s care to demonstrate continuity of care. All medical records, including all entries in the medical record, at a minimum:

- Should be organized in a manner to enable easy access to its content and should be neat, complete, clear, concise, detailed, comprehensive and timely
and include all recommendations and essential findings in accordance with good professional practice

- Must be maintained in a manner that permits effective professional medical review and medical audit processes
- Must be maintained in a manner that facilitates an adequate system for follow-up treatment
- Should include provisions for pre-natal care and all other services when appropriate
- Must be signed
- Must include the name and profession of the Provider rendering services; for example, RN, M.D., D.O., including signature or initials of Provider
- Must be legible to at least a peer of the writer and written in standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer
- Must include date of data entry and date of encounter
- Must be dated and recorded in a timely manner. Late entries should include date and time of occurrence and date and time of documentation
- Should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed
- Should only include standard abbreviations and symbols
- Must include the Member’s name or identification information on each page of the electronic or paper record
- Must include the following personal and biographical data in the record:
  - Name
  - Member ID
  - Age
  - Date of birth
  - Sex
  - Race or ethnicity
  - Address
  - Home and work addresses and telephone numbers
  - Emergency contact name and telephone numbers
  - Legal guardianship
  - Marital status
  - Name of spouse
  - Next of kin or closest relative
  - Employer
  - Insurance information
  - Family history
  - Consent forms
  - Language spoken as applicable
- Must reflect the primary language spoken by the Member and translation or communication needs of the Member. Translation or communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate
- Must prominently note any adverse drug reactions and/or food allergies or “no known allergies” and known reactions to drugs. This may include a sticker inside of the chart or prominent notation in a conspicuous place in the record
- Must easily identify the past medical history, including serious accidents, hospitalizations, operations, illnesses. For children, past medical history includes
prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox)

- As appropriate, medical records from previous Providers must be obtained and easily accessible. Old records include past medical history, physical examinations, necessary tests and possible risk factors for the Member relevant to treatment. Records must be used to assess the periodicity schedule and maintain continuity of care
- Must maintain a current immunization record in the chart pursuant to federal requirements
- Must provide a current medication list in the chart. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications
- Must identify current problems
- Must provide a problem list, with past and current diagnoses and procedures, used to ensure continuity of care is in the chart. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, health maintenance concerns, etc.
- Must identify and document history of nicotine, alcohol use or substance abuse
- Must contain information about consultations, referrals and specialist reports
- The consultation, laboratory and radiology reports filed in the medical records must contain the ordering Provider’s initials or other documentation indicating review
- Must include notations on all forms or notes regarding follow-up care, calls or visits, when indicated
- Documentation of a screening for substance abuse of tobacco, alcohol and drugs, with appropriate counseling/referrals if needed and follow-up must be documented
- Must include documentation of screening for domestic violence with appropriate counseling/referrals if needed and follow-up
- Must include documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 42 CFR 456
- Must document follow-up visits provided secondary to reports of emergency room care
- Must include hospital discharge summaries
- Must include documentation that Member has received the Provider’s office policy regarding office practices compliant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Must include documentation regarding permission to share PHI with specific individuals
- For all Members older than 18, must provide evidence that the Member was asked about or executed an advance directive, including a behavioral health directive, and there is documentation of acceptance or refusal. Note: The record must contain evidence that the Member was provided written information concerning the Member’s rights regarding advance directives and whether or not the Member has executed an advance directive. The Member does not have to have advance directives completed; a signed statement that the Member has been asked if he or she has one and if not, offering one will suffice. A stamp may be utilized. The Provider shall not, as a condition of treatment, require the Member to execute or waive an advance directive
• Must detail informed consent discussions, where appropriate
• Must document that HIV testing was offered to Members between the ages of 13 and 64 years

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

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

Inpatient Medical Record Requirements
Inpatient medical care records must contain at least the following:
• Identification data including the Member's name, address, date of birth, next of kin and a number that identifies the Member and the Member's medical record
• Medical history completed within 24 hours of admission, including the chief complaint, details of the present illness, relevant past, social and family histories and an inventory of body systems
• Relevant obstetrical records and prenatal information
• A report of the physical examination, completed within 24 hours of admission
• A statement of conclusions or impressions drawn from the admission history and physical examination
• A statement of the course of action planned for the Member while in the hospital including a periodic review of the planned course of action, as appropriate
• Diagnostic and therapeutic orders written by medical staff members (verbal orders must be authenticated)
• Appropriate informed consent
• Clinical observations
• Progress notes by the medical staff which give a chronological report of the Member’s course in the hospital and reflect changes in condition and the results of treatment
• Consultation reports that contain the consultant’s written opinion and reflect, when appropriate, an actual examination of the patient and the patient’s medical record
• Nursing notes and entries by non-physicians that contain medically relevant observations and information
• Reports of procedures, tests and their results
- A pre-operative diagnosis recorded prior to surgery by the individual responsible for the patient
- An operative report dictated or written on the medical record immediately after surgery containing a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis and the name of the primary surgeon and any assistants
- Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records and any other diagnostic or therapeutic procedures
- Clinical summary at termination of hospitalization that recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient upon discharge and any significant instructions given to the patient and family
- In teaching hospitals, the medical record must make it clear that the attending physician is providing professional services independently of the student or resident and that the notes of the student or resident only reflect her or his role as student or resident. At a minimum, the medical record must contain signed or countersigned notes which clearly specify that the physician personally reviewed the history, gave a physical examination and confirmed or revised the diagnosis and prescribed treatment. The attending physician must be recognized by the Member as the Member's personal physician
- Documentation on the discussion of advance directives and/or a completed advance directive form

Web Resources
WellCare periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare’s website frequently for the latest news and updated documents at www.wellcare.com/New-York/Providers/Medicaid.

Patient Safety Plan

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

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:
- Regular checkups for adults and children
- Prenatal care for pregnant women
- Well-baby care
- Immunizations for children, adolescents, and adults
Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, pap smears and mammograms

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

**Hospital Patient Safety Program**

WellCare is committed to offering services that promote the safe delivery of clinical care to its Members. WellCare’s Patient Safety Plan exists to establish the framework for demonstrating this commitment. Through execution of standardized internal processes and collaborative participation of hospitals, WellCare’s active patient safety program goal includes fostering a supportive environment to provide improved patient health care and safety through reduction in avoidable medical errors. Some objectives of WellCare’s Patient Safety program include, but are not limited to:

- Support of and ongoing collaboration with participating hospitals to encourage and endorse patient safety activities
- Continual monitoring of performance against national patient safety benchmarks
- Educating hospitals about safe practices

In support of safe clinical practices, WellCare’s policies and procedures define and also provide for the monitoring of nationally accepted quality of care indicators. Through tracking and trending of relevant WellCare metrics, WellCare can identify opportunities for improvement and facilitate education of a specific practitioner and/or the hospital community at large in order to reduce the potential for patient safety incidents.

WellCare addresses key elements of patient safety, such as coordination of care between hospitals, medical record review findings, adverse event and quality of care grievance tracking/trending, electronic medical records implementation, pharmaceutical management practices and Member interactions. Annually, WellCare will define the specific areas of patient safety to be monitored, which may include, but are not limited to the following metrics as indicators of safe clinical care:

- Number of quality of care complaints per 1,000 Members
- Number of adverse events reported per quarter
- Percent of physician medical records compliant to the standard of drug allergies or "NKA" recorded
- Percent of hospitals utilizing electronic medical records and automated order entry systems
- Number of therapeutic duplications and potential drug-to-drug interactions prescribed per 1,000 Members
Following the objectives as outlined in the Agreement, WellCare will utilize newsletters, Provider relations representatives, and tailored education to periodically communicate the key activities of patient safety initiative, including network patient safety performance data and survey results.

**Hospital Program Overview**
WellCare is dedicated to improving safety and reducing medical errors for patients within hospitals. Participating hospitals are required to have a Patient Safety Program to identify and resolve, through process improvement, situations that could jeopardize patient safety.

**Hospital Program Patient Safety Requirements**
Each participating hospital must implement a program with the following requirements:
- The program defines, identifies and manages risks to patient safety including medical errors throughout the organization
- Data reporting systems for the collection of data on defined processes that affect patient safety
- Implementation of pertinent best practices for reducing medical errors and enhancing positive care outcomes
- A system of classifying adverse events according to severity
- Information systems that support the program by enabling mining/trending of both administrative and clinical data to identify potential patient safety topics and facilitating activity prioritization at least semiannually
- A uniform reporting standard for adverse events, including medication errors/omissions, inappropriate use/overuse of restraints and seclusions, and delays in evaluation/testing/treatment
- Processes for annual education of staff, which includes sharing of evidence-based best practices for reducing medical errors, improving patient safety and enhancing quality of care
- Methods for ad hoc training of staff in response to an identified safety concern, to include implementation of corrective actions for continuous improvement
- Coordination of care to other levels of care as part of the discharge planning process, including the scheduling of follow-up appointments and education of patients regarding medication benefits and risks
- Mechanisms for coordination of care across disciplines and the organization
- Initial review of adverse events by a medical director, physician advisor, chief of staff or department chairperson and a mechanism for determining which incidents will be forwarded to peer review and credentialing committees
- Safety alerts and quick communication of strategies to prevent errors that show a connection to high-risk events
- Avenues for patients to participate in decisions regarding their care and to make suggestions on improving patient safety
- The sharing of evidence-based best practices for reducing medical errors, improving patient safety and enhancing quality of care

**Program Compliance**
All network hospitals accredited by the Joint Commission are expected to comply with the most current National Patient Safety Goals.
WellCare will periodically assess the status of the hospital’s efforts to improve patient safety through data measures, survey results and the hospital’s actions to further communicate performance improvement findings to WellCare Members and Providers. WellCare will also seek out and publicize any best practices identified in the promotion of patient safety in the hospital setting.

If a hospital has not been accredited by the Joint Commission or has not implemented a program, WellCare will require the hospital to submit a plan of action regarding compliance with Centers for Medicare & Medicaid Services (CMS) standards. If the plan of action is approved, WellCare will permit the hospital to become compliant with the policy within a prescribed time period provided the plan of action is implemented.

In addition, on an annual basis, WellCare will define specific measures to be monitored as indicators of safe clinical care. These will be communicated through the Provider newsletters.

Adverse Event / Incident Reporting
Any injury, regardless of degree, or any adverse or unexpected occurrence incurred by a Provider or Member should be reported to WellCare.

Incidents include any untoward or adverse event that results in death, serious impairment of bodily function or any other result that requires medical intervention other than minimal first aid treatment. Serious incidents involving WellCare Members shall be reported to the WellCare’s risk manager immediately as these incidents must be reported externally within 48 hours. Examples of such incidents are death, fetal death, brain damage, spinal damage, surgical procedure performed on the wrong patient or wrong site or wrong surgical procedure performed. The Risk Management Department phone number can be found on the Quick Reference Guide on WellCare’s website.

Other incidents involving WellCare Members that are required to be communicated to WellCare include:
- A slip or fall
- Medication error
- Reaction requiring treatment
- Abusive patient or family member
- A theft or loss from Provider’s office
- Malfunction or damage of equipment during treatment
- Accusations of malpractice by a patient or family member
- Non-compliance which may potentially be considered life-threatening

An Incident Report form should be used to report all incidents to the WellCare’s Risk Manager. The Incident Report form is on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid/Forms.

Further reporting to WellCare’s insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed timeframes by WellCare’s risk manager. Providers are reminded that serious negative events or incidents that occur in a Provider’s office or facility must be reported to the appropriate regulatory agency directly by the Provider.
Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)

Utilization Management

Overview
WellCare’s Utilization Management (UM) program is designed to meet contractual requirements and federal and state regulations while providing Members access to quality, cost-effective Medically Necessary care. For purposes of this section, terms and definitions may be contained within this section, within the Section 12: Definitions and Abbreviations of this Manual, or both.

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

WellCare’s 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 WellCare Members’ coverage, and the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

WellCare does not reward its associates or any practitioners, physicians other individuals, or entities performing UM activities for issuing denials of coverage, services or care. WellCare does not provide financial incentives to encourage or promote under-utilization.

Medically Necessary Services
All care received by WellCare Members must be “Medically Necessary” or meet “Medical Necessity,” which are defined in the definition section.

These standards are used by WellCare to determine whether benefits are covered. If services are denied by WellCare, the initial adverse determination letter will include notice of the availability, upon request of the Member or the Member’s designee, the
clinical review criteria relied upon to make such a determination. The notice will also specify what, if any, additional necessary information must be provided to, or obtained by, WellCare in order to render a decision on an appeal.

Medically Necessary or Medical Necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished on an outpatient basis or in an inpatient facility of a different type.

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

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

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

The medical review criteria stated below are updated and approved at least annually by the medical director, medical advisory committee, and quality improvement committee. 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 utilization management criteria and on instructions for applying the criteria.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:
- InterQual™ through March 3, 2019
- Milliman Clinical Guidelines (MCG), effective March 4, 2019
- WellCare Clinical Coverage Guidelines
- State Medicaid contract
- State Provider Handbooks, as appropriate
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment

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

Providers are required to notify WellCare and submit necessary clinical information for purposes of Utilization Management (UM) decision making when its Members receive care in any of the following settings:
• Acute Care Hospitals, including Critical Access Hospitals and Behavioral Health Hospitals
• Inpatient Rehabilitation Facilities
• Long-Term Acute Care Hospitals
• Skilled Nursing Facilities

The review criteria and guidelines are available to the Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting the Utilization Management Department via the WellCare Provider Services Department. The telephone number is listed on the Quick Reference Guide on WellCare’s website.

Utilization Management Process
The UM process is comprehensive and includes the following review processes:
• Notifications
• Referrals
• Prior Authorizations
• Concurrent Review
• Retrospective Review

Decision and notification time frames are determined by state law, NCQA® requirements, contractual requirements, federal regulations, or a combination of all four.

WellCare forms for the submission of notifications and authorization requests are on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid/Forms.

Adverse determinations will be made by a clinical peer reviewer.

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

Notification
Notifications are communications to WellCare with information related to a service rendered to a Member or a Member’s admission to a facility. Notification is required for:
• Prenatal services. This enables WellCare to identify pregnant Members for inclusion into the care coordination program for pregnant Members. Obstetrical Providers are required to notify WellCare of pregnancies via fax using the Prenatal Notification form as soon as possible after the initial visit. This process will expedite care management and claims reimbursement
• A Member’s admission to a hospital. This enables WellCare to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. Inpatient notification and submission of clinical information is accomplished by alerting WellCare by phone, fax or EDI 278 transaction. Participating Providers can notify WellCare via its online provider portal at: https://provider.wellcare.com/Provider/Login. The notification should be
received by fax or telephone and include Member demographics, facility name and admitting diagnosis.

**Referrals**
A referral is a request by a PCP for a Member to be evaluated and/or treated by a specialty Provider. A written or faxed script to the specialist is required. The specialist must document receipt of the request for a consultation and the reason for the referral in the medical record. No communication with WellCare is necessary. A copy of the medical consultation and diagnostic results should be submitted to the Member’s mental health or substance abuse Provider, if applicable. WellCare does not require authorization for the initial or subsequent visits when the Member is evaluated by a Participating Provider. Referral to a non-participating provider requires authorization by WellCare.

**Standing Referral to a Specialist**
Members who require ongoing care from a specialist may obtain a standing referral to an appropriate specialist. To be eligible for a standing referral, the Member must agree and have a medical condition meeting at least two of the following criteria:

- The condition is expected to require care for at least six months
- The condition is optimally managed by close monitoring of clinical or laboratory parameters and adjustment of medication or other treatment
- The primary condition may impact the treatment of other medical conditions. Typical conditions in this category would include severe asthma, brittle diabetes, unstable seizure disorders, medical management of selected transplants, acquired immune deficiency syndrome (AIDS), unstable angina, or chronic pain syndrome

To qualify for a standing referral, a specialist must meet all of the following criteria:

- He or she agrees to serve as the primary specialist for the specified condition
- The specialist has special training and experience in managing the specific condition
- He or she is currently credentialed with WellCare
- He or she is familiar with WellCare’s policies and procedures and willing to send a periodic (i.e., every six months) report to WellCare’s medical director and the Member’s PCP

In general, the physician must be a specialist or sub-specialist in a primary care specialty (pediatrics, internal medicine), or part of an academic team providing a comprehensive plan of care.

The Member may not elect to use a non-participating specialist unless there is no appropriate Participating Provider available within 45 minutes travel from the Member’s home. Prior Authorization is required by the health plan for non-Participating Providers.

If the Member is authorized for a standing referral to a non-Participating Provider, no additional cost is incurred by the Member except for that which the Member would otherwise pay for services received within the network.
Specialist as Primary Care Provider

In some cases, Members may obtain a referral to a specialist who is responsible for coordinating that Member’s primary and specialty care. To be eligible, either upon enrollment into WellCare or upon diagnosis, the Member must have either a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time. The primary care Provider, in consultation with a WellCare's medical director, must agree that the Member’s care would most appropriately be coordinated by a specialist and must agree to a treatment plan.

While acting as primary care Provider, the specialist may treat the Member without referral from the original PCP and may authorize referrals, procedures, tests, and other medical services, subject to terms of the treatment plan.

Specialty Care Centers

WellCare has established contracts with several specialty care centers, which are nationally renowned centers of excellence. These centers provide specialized treatment for conditions that have been shown to significantly affect medical outcomes.

Members with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center with expertise in treating the disease or condition. The PCP, specialist and WellCare must determine that the Member’s care would most appropriately be provided at a specialty care center. In addition, there must be evidence that the requested service is a covered benefit under the Member’s plan and is Medically Necessary.

Requests for referrals to specialty care centers for experimental or investigational therapy must meet the standards set forth in the WellCare experimental and investigational therapy policy.

A Provider or Member may request authorization for coverage of services at a specialty care center. The request must be submitted in writing to WellCare, unless a delay could cause harm to the Member. In such urgent cases, the request may be filed by telephone. A written request must include the following information:

- Name and WellCare identification number of the Member
- Diagnosis of the condition for which the Member is seeking care at a specialty care center
- Listing of any significant comorbid conditions affecting the need for specialized care
- A treatment history including the names of any specialists involved in the Member’s care
- Name, location and qualifications of the specialty care center for which the authorization is being requested

WellCare’s medical director will evaluate each request for appropriateness, considering the Member’s condition. The medical director will respond in writing to each request for authorization of services at a specialty care center. This response will include notice of:

- The authorization decision
- The clinical rationale for the authorization determination
• Appeal and complaint rights. This includes the right to file a complaint by calling WellCare’s toll-free number or by writing to WellCare’s Customer Service Department and the right to have an authorized designee file a complaint on the Member’s behalf. The Member will also be notified of the right to file an expedited appeal or complaint when a delay could reasonably be expected to harm him or her.
• The time frames for resolution of the complaint or appeal

The location of service is known to have a significant effect on the outcome of treatment for several serious medical conditions. WellCare may require, at the discretion of the WellCare medical director, information on the types of treatments to be provided at the specialty care center. For a listing of WellCare’s contracted specialty care centers, please visit www.wellcare.com/New-York and select “Find a Provider/Pharmacy” or contact WellCare’s Provider Services Department. Any services authorized under this policy will be available to the Member at no charge other than the applicable co-payments.

Prior Authorization
Prior Authorization allows for efficient use of Covered Services and ensures that Members receive the most appropriate level of care, within the most appropriate setting. Prior Authorization may be obtained by the Member’s PCP, treating specialist, or facility. Reasons for requiring Prior Authorization may include:
• Review for Medical Necessity
• Appropriateness of rendering Provider
• Appropriateness of setting
• Care and disease management considerations

Prior Authorization is required for elective, non-urgent or non-emergency services as designated by WellCare. Prior Authorization requirements by service type may be found on the Quick Reference Guide at www.wellcare.com/New-York/Providers/Medicaid or on the searchable Authorization Look-up Tool at www.wellcare.com/New-York/Providers/Authorization-Lookup.

Some Prior Authorization guidelines to note are:
• The Prior Authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure
• A Prior Authorization may be given for a series of visits or services related to an episode of care. The Prior Authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care
• The Prior Authorization request should also include any pertinent documentation to support Medical Necessity of services being requested.

The attending physician or designee is responsible for obtaining the Prior Authorization of the elective, non-urgent or non-emergency admission. 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 time frame once, for up to 14 calendar days of the post-service request. Providers are expected to meet standard non-urgent Prior Authorization guidelines and late submission of a request for Prior Authorization will result in a denial.

Providers should maintain adequate documentation to justify any services provided without obtaining the required Prior Authorization.

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.

Reasons for requiring Prior Authorization may include:
- Review for Medical Necessity
- Appropriateness of rendering Provider
- Appropriateness of setting
- Care and disease management considerations

Guidelines for Prior Authorization requirements by service type are on the Quick Reference Guide on WellCare’s website. Providers can also use the searchable Authorization Look-up Tool at www.wellcare.com/New-York/Providers/Authorization-Lookup.

Some Prior Authorization guidelines to note are:
- The Prior Authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required.
- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.

The attending physician or designee is responsible for obtaining the Prior Authorization of the elective or non-urgent admission. Refer to the Quick Reference Guide on WellCare’s website for a list of services requiring Prior Authorization.
WellCare will make a Prior Authorization decision and notify the Member and Provider, by phone and in writing within three business days of receipt of necessary information.

WellCare will fax an authorization response to the Provider fax number(s) included on the authorization request form. Providers may also be notified telephonically. Members will be notified by telephone and in writing of the authorization decision. An extension may be granted for an additional 14 calendar days if the Member or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member’s best interest.

**Expedited Prior Authorization**

In the event the Provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the Member’s life or health, WellCare will make an expedited authorization determination and provide notice within 72 hours of the request. An extension may be granted for an additional 48 hours if the Member or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member’s best interest. **Requests for expedited decisions for Prior Authorization should be requested by telephone, not fax or WellCare’s secure, online Provider Portal.** Contact WellCare’s Utilization Management Department via Provider Services at the telephone number listed on the Quick Reference Guide on WellCare’s website.

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

WellCare delegates some Utilization Management (UM) activities, including Prior Authorization of certain services, to external entities. It is the responsibility of WellCare to ensure that Delegated Entities and the functions they perform are in compliance with regulatory requirements, contractual obligations, accreditation standards and WellCare’s policies and procedures.

WellCare’s Delegated Entities can be contacted at:

<table>
<thead>
<tr>
<th>Delegated Entity</th>
<th>Authorization Number</th>
<th>Contact Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVS</td>
<td>1-866-388-1517</td>
<td>Fax</td>
</tr>
<tr>
<td>Healthplex</td>
<td>1-888-468-2183</td>
<td>Phone</td>
</tr>
<tr>
<td>eviCore</td>
<td>1-888-333-8641</td>
<td>Phone</td>
</tr>
<tr>
<td>Superior Vision</td>
<td>1-866-819-4298</td>
<td>Phone</td>
</tr>
</tbody>
</table>

For more information on delegated entities, refer to Section 9: Delegated Entities.


**Procedures for Obtaining Prior Authorization for All Medical Services Except Dental Services**
The attending physician or hospital staff is responsible for obtaining Prior Authorization from WellCare and for providing the Prior Authorization number to each WellCare
Provider associated with the case; i.e., assistant physician, hospital, etc. Failure to obtain Prior Authorization will result in denial of claim payment.

Requests for Prior Authorization should be submitted at least 10 business days prior to the planned admission or procedure. Once a procedure is approved, the approval is only valid for 60 days from the date of issuance.

In cases when Prior Authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the Member requires an additional or different procedure, the Provider should submit a request to update the original authorization and provide necessary clinical documentation to support Medical Necessity prior to submitting claim.

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

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

**Procedures for Obtaining Prior Authorization for Dental Services**
Prior Authorization is required for any dental service requiring inpatient or outpatient hospitalization. It is the responsibility of the attending dentist to obtain Prior Authorization and to provide the Prior Authorization number to the hospital. The failure of the attending dentist to obtain the correct Prior Authorization number will result in denial of payment.

For Prior Authorization of dental services requiring hospitalization, contact WellCare’s Utilization Management Department via Provider Services at the telephone number listed on the *Quick Reference Guide* on WellCare’s website.

**Authorization Request Forms**
WellCare requests Providers use standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to requests, including:

- *Inpatient Authorization* form is used to request authorization for services such as planned elective/non-urgent, inpatient, observation, sub-acute, skilled nursing facility and rehabilitation admissions
- *Outpatient Authorization* form is used to request authorization for services such as select outpatient hospital procedures, out-of-network services, and transition of care services
- *DME Ancillary Services* form is used to request authorization for durable medical Equipment
- *Home Health Services* form is used to request authorization for home care services
- *Skilled Therapy Services* form is used to request physical, occupational and speech therapy services
To ensure timely and appropriate claims payment, all forms must:

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

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

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

**Prior Authorization for Inpatient Services (Elective/Non-Urgent)**

Prior Authorization is conducted prior to a Member’s admission, stay, other service or course of treatment in a hospital or other facility. The attending physician is responsible for obtaining the Prior Authorization of the elective and/or non-urgent admission. An authorization is the approval necessary for payment to be granted for Covered Services and is provided only after WellCare agrees the treatment is necessary and a covered benefit. Authorization is not a guarantee of payment.

Hospitals should use inpatient-qualifying criteria such as Milliman Clinical Guidelines (MCG) to determine the appropriateness of an inpatient admission and conduct concurrent review of the patient's condition.

In determining if a Member’s condition requires inpatient care, WellCare determines the Medical Necessity using inpatient-qualifying criteria such as those published by Milliman Clinical Guidelines (MCG).

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

Hospital admission for diagnostic purposes is covered only when the services cannot be performed on an outpatient basis.

To substantiate the basis for the inpatient admission, the Member clinical information provided to WellCare must support Medical Necessity.


**Review and Functions for Authorized Hospitals**

Hospitals must meet the federal and state requirements for control of utilization of inpatient services including:
• Authorization and re-authorization of the need for acute care
• Treatment pursuant to a plan of care
• Operation of utilization review plans

At the time a WellCare Member is admitted into a hospital for inpatient services, the admitting physician must certify the inpatient services are Medically Necessary. The certification must be made at the time of admission, or in the case of pending eligibility, before Medicaid payment is authorized. This requirement can be met by a comprehensive note in the medical record at the time of admission.

The attending physician, or authorized representative, must re-certify that inpatient services continue to be Medically Necessary and appropriate to the acute care setting. This requirement can be met by a comprehensive progress note in the medical record at least every three to five days.

WellCare requires that a written plan of care be completed for each Member prior to authorization for payment before admission to a hospital for elective admissions, within 24 hours for emergency admissions, or for Members whose Medicaid eligibility is pending. The plan should be multi-disciplinary and should include at least the attending physician and the nursing staff. The plan must include:
• Diagnoses, symptoms or complaints indicating the need for admission
• A description of the functional level of the individual
• Medication or treatment orders
• Diet and activity level
• Plans for hospital course of treatment
• Plans for discharge

Out-of-Network Authorizations
Members will receive referral services from contracted Providers whenever possible. The Member may not use a non-participating specialist unless there is no specialist in the network who can provide the requested treatment and authorization is obtained from the health plan. Participating Providers may request a referral to an out-of-network Provider by contacting the Utilization Review Department. WellCare may authorize treatment by a non-participating Provider when no participating Provider of that service is reasonably available.

WellCare’s Utilization Review Department may authorize referrals to non-participating Providers in the following circumstances:
• The service is determined to be Medically Necessary by the Member’s PCP and WellCare
• There are no available participating Providers
• The out-of-network Provider is licensed and accredited to perform the services
• The out-of-network Provider is currently in good standing with the New York State Medicaid Board and the Office of the Inspector General
• WellCare approves the plan of treatment in consultation with the Member’s PCP and the non-Participating Provider

Special requests for out-of-network referrals (e.g., due to unique qualification of the Provider or prior involvement of the Provider in a complex treatment regimen) must be approved by WellCare’s medical director or designee.
If WellCare determines that it does not have a health care Provider with appropriate training and experience in its panel or network to meet the particular health care needs of a Member, WellCare will authorize services to an appropriate Provider, pursuant to a treatment plan approved by WellCare in consultation with the PCP, the non-Participating Provider and the Member or Member’s designee, at no additional cost to the Member beyond what the Member would otherwise pay for services received within the network.

**Reversals of Pre-Authorized Treatment**

WellCare may reverse a pre-authorized treatment, service, or procedure on retrospective review when:

- The relevant medical information presented to WellCare upon retrospective review is materially different from the information that was presented during the pre-authorization review
- The relevant medical information presented to WellCare upon retrospective review existed at the time of the preauthorization, but was withheld from WellCare or not made available
- WellCare was not aware of the existence of the information at the time of the pre-authorization review
- Had WellCare been aware of the information, the treatment, service, or procedure being requested would not have been authorized under the same criteria utilized during the preauthorization review

**Services Not Requiring Authorization**

WellCare has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of Members including:


- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require Prior Authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
  - Reproductive laboratory tests
  - Molecular laboratory tests
  - Cytogenetic laboratory tests

- Certain tests described as CLIA-waived may be conducted in the physician’s office if the Provider is authorized through the appropriate CLIA certificate. A copy of the certificate must be submitted to WellCare

All services performed without Prior Authorization are subject to retrospective review by WellCare. Emergency medical conditions do not require authorization. “Emergency condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, which a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
• Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy
• Serious impairment to such person’s bodily function
• Serious dysfunction of any bodily organ or part of such person
• Serious disfigurement of such person

**Concurrent Review**

Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, home health care services following an inpatient admission or for continued, extended or more of an authorized service than what is currently authorized by the plan, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the Member through telephonic or onsite chart review and communication with the attending physician, hospital utilization manager, Care Management (CM) staff, or hospital clinical staff involved in the Member’s care.

Concurrent review is initiated as soon as WellCare is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on InterQual™ criteria (through March 3, 2019), then Milliman Clinical Guidelines (MCG) criteria (effective March 4, 2019) for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner
- Make certain that established standards of quality care are met
- Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate
- Complete timely and effective discharge planning
- Identify cases appropriate for care management

The concurrent review process incorporates the use of InterQual™ criteria (through March 3, 2019), then Milliman Clinical Guidelines (MCG) criteria (effective March 4, 2019) to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of WellCare’s Medical Director. These review criteria are utilized as a guideline. Decisions will take into account the Member’s medical condition and co-morbidities.

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

WellCare must make a decision and notify the Member and Provider by phone and writing as fast as the Member’s condition requires and no more than:

- In the case of expedited review, within one business day of receipt of the necessary information but no more than 72 hours of an expedited authorization request;
- In the case of a request for home health care services following an inpatient admission, one business day after receipt of necessary information; except when
the day subsequent to the request falls on a weekend or holiday; but in any event no more than 72 hours after receipt of the request; or

- Inpatient Substance Abuse Disorder requested 24 hours prior to discharge from patient admission, within 24 hours of request.
- In all other cases, within one business day of receipt of the necessary information but no more than 14 days of the request.

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.

**Urgent Concurrent Authorization**

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

**Retrospective Review**

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

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

**Retrospective review initiated by Providers:**
WellCare will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions and taking into account the Member’s needs at the time of service. WellCare will also identify quality and utilization issues. Coverage determinations will not be reviewed retrospectively if the Provider has failed to follow WellCare’s Prior Authorization/pre-certification guidelines. Providers may submit evidence to support the reason for failing to follow the guidelines. If the Provider is found to be at no fault for the failure then the Provider will be allowed to submit the medical records to support Medical Necessity. If a Provider cannot submit evidence to justify the lack of Prior Authorization, the requests for retrospective medical review will be denied.

WellCare will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of all necessary information for a UM determination.

- For Medicaid/FHP, notice must be mailed to Member on the date of a payment denial, in whole or in part.

The Member or Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the Utilization Management Department via the WellCare Provider Services Department. Refer to the Quick Reference Guide on WellCare’s website.
Authorization Decisions
Failure of WellCare to make determinations within the timeframes described in this section is deemed to be an adverse determination subject to appeal. WellCare will send notice of denial on the date the review timeframes expire.

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

Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed 24 hours, however, some patients may require 48 hours of outpatient observation services.

In only rare and exceptional cases, outpatient observation services span more than 48 hours.

When a Member is placed under observation by a hospital, the patient is considered an outpatient until the patient is admitted as an inpatient. While under observation, the hospital may determine the Member needs further care as an inpatient admission or the patient may improve and be released. When Medical Necessity dictates an inpatient admission of a patient in observation, this should be billed under revenue code 762, as referred to in the billing instructions, which reflects this transaction. Observation is a covered revenue code on an inpatient claim.

WellCare does not cover outpatient observation services in the following situations:
- Complex cases requiring inpatient care, post-operative monitoring during the standard recovery period
- Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterward
- Observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, etc.

A Member may only transfer from outpatient status to inpatient status if it is determined that inpatient services are Medically Necessary. In order for the services to be covered, certification must be obtained within one calendar day of the beginning date of this episode of care. To receive authorization for an inpatient admission, WellCare must receive documentation indicating the admission is Medically Necessary and appropriate.

The date of the inpatient admission will be the actual date the Member is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient charges beginning from the date of initial observation. Outpatient observation services should not be used for services for which an overnight stay is normally expected. Services such as complex surgery, clearly requiring inpatient care, may not be billed as outpatient.
Medical appropriateness and necessity, including that of the medical setting, must be clearly substantiated in the Member’s medical record. Services provided for the convenience of the Member or physician and that are not reasonable or Medically Necessary for the diagnosis are not covered.

Procedures for Obtaining Prior Authorization for Observation Services
Observation services do not require authorization. However, pre-planned services will be held to standard authorization rules for outpatient settings. Observation should be considered if the Member does not meet acute care criteria, and any of the following apply:

- Diagnosis, treatment, stabilization and discharge can reasonably be expected within 24 to 48 hours
- The clinical condition is changing and a discharge decision is expected within 48 hours
- Complications or extended observation post ambulatory surgery/procedure
- Symptoms unresponsive to at least four hours emergency room treatment
- Psychiatric crisis intervention/stabilization with observation every 15 minutes

At 48 hours, if the Member is not stable for discharge, acute care criteria will be applied.

The decision to admit a Member continues to be the responsibility of the treating Provider. If cases arise where the circumstances would pose a hazard to the Member’s health and/or safety and the appropriate setting is in question, then the case should be referred to secondary review.

Discharge Planning
Discharge planning begins upon admission and is designed to identify medical and/or psychosocial issues that will need post-hospital intervention early. The concurrent review nurse works with the attending physician, hospital discharge planner, ancillary Providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Member to the appropriate level of care. An inpatient review nurse may refer an inpatient Member with identified complex discharge needs to short term care management for in-facility outreach.

WellCare Actions
An action is the activity of WellCare that results in a denial or limited authorization of a request for services. In the event of an action, WellCare will issue a written Initial Adverse Determination notice to the Member and the requesting Provider which will contain the following:

(a) The reasons for the determination including the clinical rationale, if any;
(b) Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals and
(c) Notice of the availability, upon request of the Member or the Member’s designee of the clinical review criteria relied upon to make such determination.
(d) The notice will also specify what, if any, additional necessary information must be provided to, or obtained by, WellCare in order to render a decision the appeal.
(e) Description of Action to be taken
(f) Statement that WellCare will not retaliate or take discriminatory action if appeal is filed
(g) Process and timeframe for filing/reviewing appeals, including Member right to request expedited review.
(h) Enrollee right to contact DOH, with 1-800-206-8125, regarding their complaint.
(i) Aid to continue form for services being stopped, restricted, reduced or discontinued
(j) Statement that notice is available in other languages and formats for special needs and how to access these formats.

Please see Section 7: Appeals and Grievances for more information.

Peer-to-Peer Reconsideration of Adverse Determination
In the event of an adverse determination following a Medical Necessity review, peer-to-peer reconsideration is offered to the treating physician on the Notice of Action communication. The treating Provider will be given a toll-free number to the medical director hotline to request a discussion with the WellCare medical director who made the denial determination. Providers have three business days to request a peer-to-peer reconsideration. The peer-to-peer reconsideration is offered within one business day following the receipt of the request by the Provider and shall be conducted by the Member’s health care Provider and the clinical peer reviewer making the initial determination.

The review determination notification contains instructions on how to use the peer-to-peer reconsideration process.

Second Medical Opinion
A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any Member of the health care team, including the Member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

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

Children with Special Health Care Needs
Children with special health care needs are adults and children/adolescents who face physical, mental or environmental challenges daily that place their health and ability to fully function in society at risk. Factors include:

- Individuals with Intellectual Disabilities or related conditions
- Individuals with serious chronic illnesses, such as HIV, schizophrenia or degenerative neurological disorders
- Individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes
- Children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that may lead to placement in foster care

Physicians who render services to Members who have been identified as having chronic or life threatening conditions should:
• Allow the Members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the Member’s condition or needs:
  o To obtain a standing authorization, the Provider should complete the appropriate authorization form and document the need for a standing authorization request under the pertinent clinical summary area of the form
  o The authorization request should outline the plan of care including the frequency, total number of visits and the expected duration of care
• Coordinate with WellCare to ensure 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 to the Member
• Ensure Members requiring specialized medical care over a prolonged period of time have access to a specialty care Provider. Members will have access to a specialty care Provider through standing authorization requests, if appropriate.
• Refer Members with special health care needs to WellCare’s Care Management Department by calling the number on the Quick Reference Guide

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

An emergency medical condition is not defined or limited based on a list of diagnoses or symptoms. Emergency services are not subject to Prior Authorization requirements and are available to Members 24 hours per day, seven days per week. Urgent care services should be provided within one day. See Section 12: Definitions and Abbreviations for definitions of “emergency” and “urgent”.

WellCare provides payment for emergency services when furnished by a qualified Provider, regardless of whether that Provider is in the WellCare network. These services are not subject to Prior Authorization requirements. WellCare will pay for all emergency services that are Medically Necessary until the Member is stabilized. WellCare will also pay for any medical screening examination conducted to determine whether an emergency medical condition exists.

WellCare will consider the following criteria when processing claims for emergency health care services:

• The age of the Member
• The time and day of the week the Member presented for services
• The severity and nature of the presenting symptoms
• The Member’s initial and final diagnosis
• Any other criteria prescribed by the DCH, including criteria specific to Members less than 18 years of age

The attending emergency room physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on WellCare, who shall be responsible for coverage and payment.

WellCare will not retroactively deny a claim for an emergency medical screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. The determining factor for payment liability shall be whether the Member had
acute symptoms of sufficient severity at the time of presentation. Payment shall be at either the rate negotiated under the Provider agreement, or the rate paid by WellCare under the Medicaid fee-for-service Agreement.

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

The Member cannot be billed for the screening and/or treatment needed to stabilize such Member.

Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at the applicable triage rate, or as otherwise specified in the hospital contract. The triage rate covers all ancillary services rendered as well as the fee for use of the emergency room. This triage rate may be subject to the hospital’s contracted reimbursement rate; in other words, the triage rate may not be the reimbursement rate in all cases. This triage rate includes any applicable Member co-payment. The triage rate is for the medical screening examination and stabilization services provided in the emergency room without regard to Prior Authorization.

If the hospital thinks the medical record supports the existence of a true emergency situation, but the initial presenting information on the claim may not be identified as a true emergency, the claim may be submitted by hard copy with documentation. The claim will suspend for medical review retrospectively against the prudent layperson criteria, and additional criteria outlined previously, and applicable payment applied.

If a triage rate was received, and the presenting claim did not clearly provide information for determining the presence of an emergency, additional documentation may be submitted for a medical retrospective review. A single form can be submitted with one or multiple claims. Each claim submitted should contain new information that provides complete insight on the Member’s visit to the emergency department. All claims will be reviewed and a follow-up letter of determination (upheld or overturned) will be sent for each claim. In the event a claim decision is overturned based on the additional documentation, WellCare will automatically reprocess the claim at the appropriate emergency department payment rate determined by the Provider contract. In the event the emergency department triage decision is upheld through this informal emergency department reconsideration process, a Provider can still submit the claim for review under the formal appeals process. Submit all retrospective emergency department review requests to the retrospective review team.

If, after medical review, the determination is made that an emergency or potential emergency did in fact exist, the services will be reimbursed at the hospital’s specific outpatient contracted rate. Accurate coding is critical to ensure proper reimbursement.

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

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

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

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

**Continuity of Care**

WellCare will allow Members in active treatment to continue care with a terminated treating Provider, when such care is Medically Necessary, through completion of treatment of a condition for which the Member was receiving care at the time of the termination, until the Member selects another treating Provider, or during the next open enrollment period. None of the above may exceed six months after the termination of the Provider’s contract. In no instance will care be authorized if the Provider’s contract was terminated for cause i.e. fraud, sanctioned, etc.

WellCare will allow pregnant Members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating Provider until completion of postpartum care.

For continued care under this provision, the Provider must agree to:

- Continue to accept reimbursement at rates applicable prior to transitional care
- Adhere to the organization’s quality assurance program and provide medical information related to the Member’s care
- Adhere to WellCare’s policies and procedures including referrals and obtaining pre-authorization and a treatment plan approved by the organization

**Transition of Care**

**Transition of Care for New Members Transitioning into WellCare**

During the first 60 days of enrollment, authorization is not required for certain Members with previously approved services by the state or another managed care plan. WellCare will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval. However, notification to WellCare is necessary to properly document these services and determine any necessary follow-up care.

When relinquishing Members, WellCare will cooperate with the receiving health plan regarding the course of on-going care with a specialist or other Provider.
When WellCare becomes aware that a covered Member will be dis-enrolled from WellCare and will transition to a Medicaid fee-for-service program or another managed care plan, a WellCare review nurse/care manager who is familiar with that Member will, upon request, provide a transition of care report to the receiving plan, or appropriate contact person for the designated fee-for-service program.

If a Provider receives an adverse claim determination which they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals Department with appropriate documentation. Refer to the Quick Reference Guide on WellCare’s website for the Appeals Department contact information.

**Transition of Care for New Members Whose Provider is Out-of-Network**

A new Member whose health care Provider does not participate in the WellCare network will be permitted to continue an ongoing course of treatment with the Member’s current health care Provider during a transitional period. The transitional period extends up to 60 days from the date of enrollment. If a new Member is pregnant and has entered her second trimester of pregnancy at the effective date of enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of post-partum care directly related to the delivery up to 60 days after the delivery.

New Members may continue their course of treatment with the non-participating Provider if all of the following criteria are met:

- The Member elects to continue to receive care from a non-participating health care Provider by notification to WellCare
- The services are authorized by WellCare
- The Member has a life-threatening disease or condition or a degenerative and disabling disease or condition
- The non-participating health care Provider agrees to accept the WellCare fee schedule as full rate of reimbursement less any applicable Member co-payment
- The non-Participating Provider agrees to adhere to the WellCare’s quality assurance requirements and agrees to provide medical information about care being provided
- The non-Participating Provider agrees to adhere to WellCare’s policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization. The non-Participating Provider must have a treatment plan approved by WellCare

**Transition of Care When a Provider Leaves WellCare’s Network**

For existing Members whose Provider has left WellCare’s network will be permitted to continue their on-going course of treatment with that Provider for a transitional period of up to 90 days from the date the Provider’s contractual obligation terminates. If the existing Member has entered their second trimester of pregnancy, their transitional period will include the provision of post-partum care directly related to the delivery through 60 days post-partum.

- If the Member elects to continue to receive care, such care shall be authorized by the plan for the transitional period only if the non-Participating Provider agrees to continue to accept reimbursement at rates applicable prior to transitional care
- Adhere to WellCare’s quality assurance program and provide medical information related to the Member’s care
• Adhere to WellCare’s policies and procedures including:
  o Referrals
  o Obtaining pre-authorization
  o Completing a treatment plan approved by WellCare

However, in no instance will this care be authorized if the Provider’s contract has been terminated for cause, i.e. fraud, disciplinary actions such as sanctions by the State, etc.

**Out-of-State Providers and Service Limitations**

Out-of-state hospital Providers not contracted with WellCare will be reimbursed for Covered Services provided to eligible WellCare Members while out-of-state if the claim is received within 15 months from the date of service, and if at least one of the following conditions is met:

- The hospital Provider preauthorized the service through WellCare
- The service was provided to the WellCare Member as a result of an emergency or life-endangering situation occurring out-of-state. If the out-of-state Provider thinks the medical record supports the existence of an emergency situation, but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical record

Routine health care or elective surgery provided by out-of-state Providers is not covered unless Prior Authorization is obtained from WellCare. In order to receive Prior Authorization, the referring in-state Provider is required to request prior approval by documenting in writing the Medical Necessity of obtaining services out-of-state and providing the name and address of the out-of-state medical Provider. Provider reimbursement and coverage of out-of-state services are determined in accordance with current policies and procedures of WellCare and are contingent upon the patient’s eligibility at the time services are provided.

Requests for prior approval or questions regarding out-of-state services must be directed to the WellCare Provider Services Department. Refer to the *Quick Reference Guide* on WellCare’s website.

If services are pre-authorized, a copy of the authorization letter from WellCare must be attached to out-of-state claims submitted for reimbursement.

Services rendered due to an emergency or life-endangering situation do not have to be pre-authorized. Any emergency service, rendered by a non-par Provider and identified by WellCare as emergent, is reimbursable at current Medicaid rates for these services.

**Recipient Restriction Program**

WellCare may restrict the number of Providers from whom a Member may receive services. Members who have demonstrated a pattern of utilization abuse are placed in the program once they have failed to correct the behavior even after notification from WellCare.

In the Recipient Restriction Program, a Member who has consistently utilized services at a frequency or amount that is not Medically Necessary is locked in to a single physician and pharmacy Provider selected by WellCare. The Provider chosen will be geographically situated to give reasonable access to the Member. The initial restriction period will not exceed 12 months. Following the restriction period, the Member’s usage...
is re-evaluated to determine if continuation of the restriction is necessary. A Member facing restriction will be given notice of a hearing prior to the restriction. The restriction does not apply to emergency services or if a specialized Provider is Medically Necessary.

The physician and pharmacy selected by WellCare to participate in the restriction will be contacted by WellCare prior to the start of the restriction period, and that physician and/or pharmacy may decline to participate.

Claims submitted for a Member in restricted status by Providers other than those selected will be denied.

If a hospital suspects a Member seeking services of a non-emergent nature is in the Restriction program, the hospital should contact the Provider listed on the Member’s Medicaid ID card. The Provider listed on the ID card is to be considered the Member’s attending physician and should be consulted prior to providing services of a non-emergent nature. Hospitals should be alert to possible abuse of emergency room services to prevent the hospital from incurring costs for non-reimbursable expenditures.

Further, Providers are asked to identify and report emergency room abuse by Medicaid Members who are not currently monitored by the Restriction program to WellCare. For more information, refer to the Quick Reference Guide on WellCare’s website.

Hospitalist Program
Hospitalists provide attending physician coverage in selected markets for Members admitted to contracted facilities. Hospitalists provide the following services:

- Emergency room assessment of a Member
- Direct admissions to facilities where the PCP may not provide that service
- Care management as needed throughout the inpatient medical admission for Members, excluding obstetrical and gynecological cases
- Member referrals to the PCP upon discharge for follow-up care and communicating the treatment/discharge plan verbally within 24 hours and in writing within seven days

Limits to Abortions, Sterilizations and Hysterectomy Coverage
The following services have special requirements from the State of New York.

Abortion
Family planning and reproductive health services include Medically Necessary induced abortions, which are procedures, either medical or surgical, that result in the termination of pregnancy. The determination of Medical Necessity shall include positive evidence of pregnancy with an estimate of its duration. A consent form is not required for termination of pregnancy.

Sterilizations
Prior Authorization is not required for sterilization procedures. However, WellCare will deny any Provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.
WellCare is prohibited from making payment for sterilizations performed on any person who is:

- Under 21 years of age at the time he or she signs the consent
- Not mentally competent
- Institutionalized in a correctional facility, mental hospital or other rehabilitation facility

The required *LDSS-3134 Sterilization Consent Form* must be completed and submitted to WellCare.

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

The signed consent form expires 180 calendar days from the date of the Member's signature.

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

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

**Hysterectomy**

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

- The Provider ensured the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy)
- Prior to the hysterectomy, the Member/individual and the attending physician must sign and date the *Acknowledgement of Hysterectomy Information* form
- In the case of prior sterility or emergency hysterectomy, a Member is not required to sign the consent form
- The Provider properly executes the *Waiver of Acknowledgement and Surgeon’s Certification* section on the *Acknowledgement of Hysterectomy Information* form with the claim prior to submission to WellCare

WellCare will deny payment on any claim(s) submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant to satisfy informed consent requirements that has been completed or altered after the service was performed.
Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for Medical Necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization, but does need to be submitted with the claim.

All forms are located on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid/Forms.

**Short Term Care Management**
The goal of short term care management (SCM) is to ensure that complex, high-risk Members are discharged with a safe and effective plan in place, to promote Members’ health and well-being, and reduce avoidable readmissions. The SCM will refer Members with long-term needs to CM or Disease Management.

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

The SCM’s work includes, but is not limited to:
- Screening for Member needs
- Education
- Care coordination
- Medication reconciliation
- Referrals to community-based services

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

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

In order to receive a delegation status for UM activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required UM standards. There must be a mutually agreed upon written delegation agreement describing the utilization activities delegated and those responsibilities of WellCare, and the entity must be licensed in New York to provide these services.

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

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

Care Management Program
WellCare offers comprehensive integrated Case Management (CM) services to facilitate Member assessment, planning and advocacy to improve health outcomes for Members. WellCare trusts Providers will help coordinate the placement and cost-effective treatment of Members who are eligible for WellCare CM Programs.

WellCare’s multidisciplinary CM teams are led by specially trained Registered Nurses (RN) or Licensed Clinical Social Workers (LCSW) who perform a comprehensive assessment of the Member’s clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan. The CM teams work collaboratively with PCPs and specialists to coordinate care for the Member and expedite access to care and needed services.

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

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

WellCare’s philosophy is that the CM Program is an integral management tool in providing a continuum of care for WellCare Members. Key elements of the CM 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 to identify the best way to fill any identified gaps or barriers to improve access and adherence to the Provider’s plan of care. The Member, or in the case of a minor, the parent or legal guardian, and the PCP receives a copy of the initial care plan and any subsequent care plans made due to changes in Member status.
• 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 finding the services to optimize their health. CM emphasizes continuity of care for Members through the coordination of care among physicians, Community Mental Health Centers and other Providers.

Members commonly identified CM Program include those Members with:

- **Catastrophic Injuries** such as traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas
- **Multiple Chronic Conditions** such as multiple co-morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple intricate barriers to quality health care, i.e., AIDS
- **Transplantation** such as organ failure, donor matching, post-transplant follow-up
- **Complex Discharge Needs** – Members discharged home from acute inpatient or skilled nursing facility (SNF) with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated non-healing wounds, advanced illness, etc.
- **Special Health Care Needs** such as children or adults who have serious medical or chronic conditions with severe chronic illnesses, physical, behavioral and developmental disabilities

**Disease Management Program**

**Overview**
Disease Management (DM) is a population-based strategy that involves providing 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’s adherence to the treatment plan, and the consistent use of validated, industry-recognized evidence-based Clinical Practice Guidelines by the treatment team as well as the Disease Manager.

The DM Program targets the following conditions:

- Asthma - adult and pediatric
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- COPD
- Diabetes - adult and pediatric
- HIV/AIDS
- Hypertension
- Depression
- Smoking cessation

WellCare’s DM Program educates Members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The program also focuses on educating the Provider regarding the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of Members, improve health outcomes and decrease medical costs. Providers and Members can get general information regarding health conditions on WellCare’s website.
Candidates for Disease Management
WellCare’s DM Member identification strategy leverages multiple channels for identifying those Members who could most benefit from the DM Program services. Key Member identification channels include data mining and risk stratification monthly through proprietary claims, utilization management, discharge, and pharmacy data algorithms. WellCare also 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 and 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 can be found on WellCare’s website.

Access to Care and Disease Management Programs
To refer a WellCare Member as a potential candidate to the CM Programs or the DM Program, or would like more information about one of the programs, call the WellCare CM Referral Line. Members may self-refer by calling the CM toll-free line or contacting the Nurse Advice Line after hours or on weekends (TTY/TTD available).

For more information on the CM Referral Line, refer to the Quick Reference Guide on WellCare’s website.
Section 5: Claims

The focus of WellCare’s Claims Department is to process claims in a timely manner. Providers should contact the WellCare Provider Services Department for claims assistance. For more information, refer to the Quick Reference Guide on WellCare’s website.

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.


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

Timely Claims Submission

Pursuant to Social Services Law § 364-j (24) and 369-ee (3) (i), and Public Health Law § 2511(19), for in-network Providers, claims must be submitted within 120 days from the date of service to the primary payers, unless otherwise indicated in the Provider Agreement. WellCare as a secondary payer must receive claims within 90 days from the date of the primary carrier’s explanation of payment (EOP) unless otherwise specified by contractual agreement.

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

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by WellCare
- A Provider’s electronic submission sheet with all the following identifiers, including patient name, Provider name, date of service to match Explanation of Benefits (EOB)/claim(s) in question, prior submission bill dates, and WellCare product name or line of business

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

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

**Tax Identification (TIN) and National Provider Identifier (NPI) Requirements**
WellCare requires the payer-issued Tax Identification (Tax ID/TIN) and 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 HIPAA’s NPI Final Rule Administrative Simplification, is available on the CMS website at [www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand](http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand).

**Taxonomy**
Providers are 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, Providers must include this number in the appropriate data field on the claim.

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

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

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, please review the “Encounters Data” section below.

**Claims Submission Requirements**
WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare utilizes the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM), or later, for all coding. In addition, the CPT-4 coding and/or HCPCS is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the hospital must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

WellCare tracks billing codes and Providers who continue to apply incorrect coding rules. Providers will be educated on the proper use of codes as a part of the retrospective review process. Should a Provider continue to repeat the inappropriate coding practice, the Provider will be subject to an adverse action.
Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the HIPAA-compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider’s NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that Covered Service is fully and accurately documented in the Member’s medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member and/or Non-Covered Services. For more information on paper submission of claims, refer to the Quick Reference Guide on WellCare’s website.

Electronic Claims Submissions
WellCare accepts electronic claims submission through electronic data interchange (EDI) as its preferred method of claims submission. All files submitted to WellCare must be in the ANSI ASC X12N format, version 5010A or its successor. For more information on EDI implementation with WellCare, refer to the WellCare Companion Guides on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid/Claims.

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

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

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

For more information on EDI implementation with WellCare, refer to the WellCare Companion Guides on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid/Claims.

Paper Claims Submissions
For timelier processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties as specified in the Agreement. For assistance in creating an EDI process, contact WellCare’s EDI team by referring to the Quick Reference Guide on WellCare’s.

If permitted under the Agreement and until the Provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:
• Paper claims must only be submitted on an original (red ink on white paper) claim form
• Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly
• Per CMS guidelines, the following process should be used for Clean Claims submission:
  o **The information must be aligned within the data fields and must be:**
    ▪ On an original red-ink-on-white-paper claim forms
    ▪ Typed. Do not print, handwrite, or stamp any extraneous data on the form
    ▪ In black ink
    ▪ Large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type
    ▪ In capital letters
  o **The typed information must not have:**
    ▪ Broken characters
    ▪ Script, italics or stylized font
    ▪ Red ink
    ▪ Mini font
    ▪ Dot matrix font

CMS Fact Sheet about CMS-1500 02/12 Version

CMS Fact Sheet about UB-04:

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

Two Day Payment Window
WellCare follows the CMS guidelines for outpatient services treated as inpatient services (including but not necessarily limited to: outpatient services followed by admission before midnight of the following day, preadmission diagnostic services, and other preadmission services).

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 an adjustments to the Provider’s claims payment or request for review of medical records, prior to or subsequent to payment, 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, and thus Providers must not bill or collect payment from Members for such reductions in payment.

Prompt Payment
Claims are to be processed in accordance with the terms of the Member’s plan of benefits and in compliance with WellCare’s Contract with NY SDOH.

At least 98 percent of Clean Claims submitted in a calendar year via the Internet or electronic mail must be paid within 30 days of receipt.

At least 98 percent of Clean Claims submitted in a calendar year by other means, such a paper or facsimile, must be paid within 45 days of receipt.

Coordination of Benefits
WellCare shall coordinate payment for Covered Services in accordance with the terms of a Member’s Benefit Plan, applicable state and federal laws and CMS guidance. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan as well as a copy of the EOB. WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers must follow WellCare policies and procedures regarding subrogation activity.

Encounters Data
Overview
This section is intended to provide delegated vendors and Providers (IPAs) with the necessary information to allow them to submit encounter data to WellCare. This requirement is mandated to meet the reporting requirements of WellCare as well as those established by regulatory agencies and the Balanced Budget Act. If encounter data does not meet the service level agreements for timeliness of submission, completeness or accuracy, the State has the ability to impose significant financial sanctions on WellCare. WellCare requires all delegated vendors and delegated Providers to submit encounter data, even if they are reimbursed through a capitated arrangement.

Timely and Complete Encounters Submission
Unless otherwise stated in the Agreement, vendors and Providers should submit complete, timely and accurate encounter files to WellCare as follows:

- Encounters submission will be weekly
- 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 as per the state requirements. SNIP Levels 1 through 5 shall be maintained. Once WellCare receives a delegated vendor’s or Provider’s encounters, the encounters are loaded into WellCare’s encounters system and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on the Workgroup for Electronic Data Interchange (WEDI) SNIP edits, refer to their website at [www.wedi.org](http://www.wedi.org). For more information on submitting encounters electronically, refer to the [WellCare Companion Guides](http://www.wellcare.com/New-York/Providers/Medicaid/Claims) on WellCare’s website at **www.wellcare.com/New-York/Providers/Medicaid/Claims**. Vendors are required to comply with any additional encounters validations as defined by the State and/or CMS.

**Encounters Submission Methods**

Delegated vendors and Providers may submit encounters using several methods:

- Electronically
- Through WellCare’s contracted clearinghouse(s)
- Via DDE
- Using WellCare’s Secure File Transfer Protocol (SFTP) process

**Submitting Encounters Using WellCare’s SFTP Process (Preferred Method)**

WellCare accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using WellCare’s SFTP process. Refer to WellCare’s ANSI ASC X12 837I, 837P and, 837D Health Care Claim / Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. For more information on EDI implementation with WellCare, refer to WellCare’s website at [www.wellcare.com/New-York/Providers/Medicaid/Claims](http://www.wellcare.com/New-York/Providers/Medicaid/Claims).

**Submitting Encounters Using Direct Data Entry (DDE)**

Delegated vendors and Providers may submit their encounter information directly to WellCare using WellCare’s DDE portal. The DDE tool can be found on the secure, online Provider Portal at [www.wellcare.com/New-York/Providers](http://www.wellcare.com/New-York/Providers). For more information on free DDE options, refer to the New York Medicaid Provider Resource Guide on WellCare’s website at [www.wellcare.com/New-York/Providers/Medicaid](http://www.wellcare.com/New-York/Providers/Medicaid).

**Encounters Data Types**

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

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

This document is intended to be used in conjunction with WellCare’s ANSI ASC X12 837I, 837P and, 837D Health Care Claim / Encounter Institutional, Professional and, Dental Guides.

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

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

**Balance Billing**
 Providers shall accept payment from WellCare for Covered Services provided to WellCare Members in accordance with the reimbursement terms outlined in the Provider’s participating provider 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

**Non-Covered Services**
A Provider is prohibited from seeking payment from a Medicaid recipient for Non-Covered Services (either fee-for-service or managed care) unless the Provider has advised the Member prior to initiating service that the service is not a covered benefit and has advised the Member of its cost. The recipient has to consent in writing and is must be fully Non-Covered Service.
Non-Participating Providers and Private–Pay Members
A Provider who participates in Medicaid fee-for-service but does not participate with WellCare may not bill Medicaid fee-for-service for any services that are included in the managed care plan, with the exception of family planning services. The Provider also may not bill the Member for services that are covered by WellCare unless there is a prior agreement with the Member that he or she is being seen as a private-pay patient. The Provider must inform the Member that the services may be obtained at no cost to the Member from a Provider who participates with WellCare. This must be a mutual and voluntary agreement. It is suggested that the Provider maintain the patient’s signed consent to be treated as private pay in the patient record.

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

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:
- A different procedure altogether
- The correct procedure but on the wrong body part
- The correct procedure on the wrong patient

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

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

Hold Harmless Dual– Eligible Members
Those dual-eligible Members whose Medicare Part A and B Member expenses are identified and paid for at the amounts provided for Medicaid shall not be billed for such Medicare Part A and B Member expenses, regardless of whether the amount a Provider receives is less than the allowed Medicare amount or Provider charges are reduced due to limitations on additional reimbursement provided by Medicaid.

Claims Disputes
The claims dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to WellCare in writing within 90 days of the date of denial of the EOP.

Documentation consists of:
- Date(s) of service
- Member name
- Member WellCare ID number and/or date of birth
- Provider name
• Provider Tax ID/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 mail to the address, or fax to the fax number, listed on the Quick Reference Guide on WellCare’s website.

**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 the original WellCare claim number and bill frequency code per industry standards.

Example:

<table>
<thead>
<tr>
<th>Box 4 – Type of bill: the third character represents the “Frequency Code”</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>F8</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Box 64 – Place the claim number of the prior claim in Box 64</th>
</tr>
</thead>
<tbody>
<tr>
<td>298370064</td>
</tr>
</tbody>
</table>

- For Professional claims, the Provider must include the original WellCare claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 OR 8</td>
</tr>
<tr>
<td>123456789012A33456</td>
</tr>
</tbody>
</table>
Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

Please Note: If the Provider handwrites, stamps, or types “corrected claim” on the claim form without entering the appropriate Frequency Code “7” or “8” along with the Original Reference Number as indicated above, the claim will be considered 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 codes based on the place of treatment (physician office services versus other places of treatment).

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

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

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

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

**Multiple Procedures**
Payment for multiple procedures is based on:

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

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

Assistant Surgeon

Assistant Surgeons are reimbursed at 16 percent of the maximum allowable fee for the procedure code. Multiple surgical procedures for assistant surgeons are reimbursed as follows:

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

WellCare uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes,” CMS is used as the secondary source.

Allied Health Providers

If there are no reimbursement guidelines on the New York Medicaid website specific to payment for non-physician practitioners or allied health professionals, WellCare follows CMS reimbursement guidelines regarding allied health professionals.

Hospital-Based Physicians, Certified Registered Nurse Anesthetists and Nurse Practitioners

All inpatient and outpatient professional services must be billed on the physician's claim form.

Hospital-based physicians, certified registered nurse anesthetists (CRNAs), specified nurse practitioners and physician assistants (PAs) may designate the hospital as payee by agreement. The hospital must maintain each agreement authorizing such payments on file.

Services rendered to eligible Members by hospital-based physicians, CRNAs, designated nurse practitioners and PAs will be covered both on an inpatient and outpatient basis as long as the services are Medically Necessary and within the contractual or financial agreement with the hospital. These services are subject to retrospective review by WellCare or its authorized agents.

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. Per the NY Insurance Law § 3224-b, WellCare shall have and retain the right to audit participating Providers’ claims for a period of six years from the date the care, services or supplies were provided or billed, whichever is later. However, no such time limit shall apply to overpayment recovery efforts that 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 this 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 days for the Provider to send in the refund or contact WellCare, or its designee, for further information or to dispute the overpayment.

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

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

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

For more information on contacting the WellCare Provider Services Department, refer to the *Quick Reference Guide* on WellCare’s website.
Section 6: Credentialing

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 this Credentialing section, all references to “practitioners” shall include Providers delivering health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations.

This evaluation includes (as applicable to practitioner type):

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

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

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

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank
- Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network Providers of services to WellCare Members
- Satisfactory site inspection evaluations are required to be performed in accordance with state, federal, state and accreditation requirements
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider
- WellCare will complete credentialing activities and notify Providers within 60 days of receiving a completed application. The notification to the Provider will inform them as to whether they are credentialed, whether additional time to complete
the credentialing process is needed, or that additional Providers are not needed at the time. When additional information is needed to complete a Provider application, WellCare will make the request from the Provider as soon as possible, and no later than 60 days from the receipt of the application. WellCare will also communicate with Providers within these time frames throughout the Provider re-credentialing process.

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) standards and WellCare requirements.

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

**Practitioner Rights**

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

**Practitioner’s Right to Be Informed of Credentialing/Re-Credentialing Application Status**

Written requests for information may be emailed to credentialinginquiries@wellcare.com. Upon receipt of a written request, WellCare will provide written information to the practitioner 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 her or him 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 includes:
- 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 Credentialing to whom corrections must be sent
- WellCare’s documentation process for receiving the correction information from the provider
- WellCare’s review process

**Baseline Criteria**
Baseline criteria for practitioners to qualify for Provider network participation:

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

**Drug Enforcement Administration Certificate** – Practitioners must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current 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 must have hospital-admitting privileges at a WellCare-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another WellCare-participating Provider who has admitting privileges at a WellCare-participating hospital for the admission of Members.

**Ability to Participate in Medicaid and Medicare** – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare Company Plan. Providers are not eligible for participation if such Provider owes money to the Medicaid Program or if the Office of the Attorney General has an active fraud investigation involving the Provider. Existing Providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with WellCare policy and procedure.

**New Providers** – A Provider must have an NPI to participate in WellCare’s network.
**Liability Insurance**
WellCare Providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits of $1 million per occurrence and $3 million aggregate, 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 that do not have a State or CMS SIE to provide
- When a complaint is received relative to office site criteria

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

**Covering Providers**
PCPs in solo practice must have a covering Provider 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:
- Advanced registered nurse registered nurse practitioners (ARNP)
- Certified nurse midwives (CNM)

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 a SIE if unaccredited. WellCare is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage prior to accepting the applicant as a WellCare Provider.

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

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

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

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials
On a regular and ongoing basis, WellCare or its designee contacts state licensure agencies to obtain the most currently 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.

Corrective Action and Termination Policy
WellCare may initiate a corrective action and/or termination for any participating individual physician, Provider independent physician association (IPA), and/or group whenever a Provider engages in, or exhibits acts, statements, or demeanor which is reasonably likely to be:

- Detrimental to patient safety or quality of care
- Contrary to state or federal laws or regulations
- Contrary to WellCare bylaws, policies, procedures or standards
Corrective actions may be initiated by WellCare’s Executive Management, the medical director, board of directors, or by any one of the standing committees including the Clinical Quality Improvement Committee, Credentialing Committee, and Quality Improvement Council. A review action will be taken after reasonable efforts have been made to obtain the facts of the matter and after adequate notice of the proposed action and the reasons for the proposed action. WellCare will issue a notice of hearing rights and procedures, as appropriate. However, advance notice may not be given if it is detrimental to patient safety.

WellCare may choose to not renew a Provider’s contract at the expiration of the contract period or, for a contract without a specific expiration date, on each January 1 occurring after the contract has been in effect for at least one year, or any time with 60 days written notice, or as specified in the Provider contract.

WellCare may terminate a Provider for cause with 60 days’ notice or as specified in the Provider contract. WellCare may also terminate a Provider’s contract immediately following a determination of imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice. Again, advance notice may not be given if it is detrimental to patient safety.

**Medicaid**

Providers who are sanctioned by the DOH’s Medicaid Program will be excluded from participation in WellCare’s Medicaid panel. No Provider will be terminated solely because he or she has:

- Advocated on behalf of a Member
- Filed a complaint against WellCare
- Appealed a WellCare decision
- Disclosed to a Member, or a Member’s designee, any information regarding a condition or course of treatment, including the availability of other therapies, consultations or tests
- Disclosed to a Member, or a Member’s designee, information regarding the provisions, terms, or requirements of WellCare’s products as they relate to the Member
- Filed a complaint, made a report or commented to an appropriate governmental body regarding the policies or practices of which the Provider thinks may negatively impact upon the quality of, or access to, patient care
- Requested a hearing pursuant to this policy

Providers shall inform WellCare’s medical director in writing upon discovery or notification of any of the following actions taken against the Provider:

- Loss of license
- Sanctions, restrictions, and/or limitations in scope of practice as defined by the state licensing agent
- Loss or limitation of hospital privileges; loss or surrender of a DEA license or CDS certificate
- Loss of malpractice insurance
- Professional liability claims settlement
Corrective Action and Termination for Cause
Requests for an administrative review for corrective action will be made in writing and will be forwarded to either the medical director for clinical concerns or the director of network management/quality improvement for administrative issues. Review requests may include, but are not limited to:

- Documentation of repeated complaints from Members, where after notification the Provider has failed to correct the problem
- Repeated failure to follow procedure after notice of expectation and correct procedure
- Misrepresentation of credentials in application process or failure to submit documents on re-credentialing
- Documented material breach of contract
- Breach of ethics (e.g. breach of confidentiality, receiving remuneration for patient referral)
- Intentional submission of duplicate or false claims for payment
- Documentation of professional misconduct and/or unprofessional conduct
- Failure to participate in quality assurance process
- Any other deficiency that is determined to indicate substandard or unacceptable future performance in the quality of care or service

The request must be submitted with all appropriate documentation of the issue, associated correspondence with the Provider, including prior attempt to resolve the issue and documentation of the Provider’s non-compliance.

The request will be reviewed by medical management or the Quality Improvement Committee or a designated subcommittee for clinical issues or an administrative review board for non-clinical issues. The administrative review board is an ad hoc committee and will consist of the medical director, executive management and the director of network management.

The QIC or administrative review board shall direct such investigation or may delegate the investigation to the medical director or peer review subcommittee. The process may include:

- Written rebuttal from the practitioner(s) involved
- A conference with the practitioner(s)
- Meeting with the individual or group requesting the action, or any other individuals who may have knowledge of the event involved

The request for review may be rejected at any point in this process if it is determined that the issue is not substantiated by the documentation.

If the investigation concludes that a corrective action is warranted, the appropriate committee will document the findings and a letter will be sent within 30 days of the decision in a certified letter to the practitioner(s) involved for a response prior to initiation of a corrective action. The practitioner(s) will have 30 days from receipt of this letter to respond. The response will be reviewed by the initiating Committee to determine what further action should be taken, if any.

The Committee may recommend one or more of the following actions after completion of the review process:
• Rejection of the request for corrective action
• A verbal warning to the Provider(s) involved
• A formal letter of reprimand with request for plan of corrective action
• Additional education and/or training
• A probationary period of prescribed duration with retrospective review of cases, medical records, and professional behavior
• Financial sanctions
• Non-renewal, suspension or termination of plan participation
• Automatic suspension or termination may be imposed if the circumstances are determined to warrant this action

Once a decision has been made to administer a corrective action or terminate a Provider for cause, the Provider will receive written notification of the proposed action that shall include:
• The reasons for the proposed action
• Notice that the Provider has the right to request a hearing or review, at the Provider’s discretion, before a panel appointed by WellCare
• Notice that the Provider has 30 days within which to request his hearing
• Notice that the hearing must be held within 30 days after the date of the receipt of a request for a hearing

The practitioner(s) will have the right to a fair hearing upon notification of the determinations or recommendations.

In all instances where the committee convenes and/or investigates for corrective action, complete documentation will be maintained in the quality improvement file and credentialing file. This will include the substance of the complaint and a written plan for follow-up if applicable on a monthly, quarterly or semi-annual basis, along with the person and committee assigned responsibility to implement the follow-up plan. The assigned committee will review the Provider at the prescribed intervals and documentation will be maintained in the file.

**Immediate Terminations**
A Provider may be terminated immediately from WellCare’s network if any of the following situations occurs:
• In the opinion of the medical director there is a threat of imminent harm to patient care
• The Provider ceases to be duly licensed to practice in the State of New York
• The Provider is the subject of a determination of fraud
• The Provider is deceased or retires from active participation in a medical practice

A Provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice is not eligible for a hearing or review.

The medical director, the chief executive officer, or the chairman of the board may evoke immediate termination by notification to the Provider and to the credentialing office.
In accordance with federal and state regulatory requirements, WellCare will make additional reports to the appropriate professional disciplinary agency and to the National Practitioner Data Bank.

No Provider will be terminated solely because he or she has:
- Advocated on behalf of a Member
- Appealed a decision by WellCare
- Disclosed to a Member, or a Member’s designee, any information regarding a condition or course of treatment, including the availability of other therapies, consultations or tests
- Disclosed to a Member, or a Member’s designee, information regarding the provisions, terms, or requirements of WellCare’s products as they relate to the Member
- Filed a complaint against WellCare, made a report or commented to an appropriate governmental body regarding WellCare’s policies or practices of which the Provider thinks may negatively impact upon the quality of, or access to, patient care
- Requested a hearing pursuant to the policies outlined in this Manual or in the Agreement

Providers shall inform WellCare’s Medical Director in writing upon discovery or notification of any of the following actions taken against the Provider:
- Loss of license
- Sanctions, restrictions, and/or limitations in scope of practice as defined by the state licensing agent
- Loss or limitation of hospital privileges
- Loss or surrender of a DEA license or CDS certificate
- Loss of malpractice insurance
- Professional liability claims settlement

WellCare will not terminate a contract with a Provider unless it provides the Provider with a written explanation for the proposed contract termination and an opportunity for a review or a hearing as described in the following section.

**Provider Hearing for Terminations**

In accordance with state laws and contractual obligations, the Provider will receive written notification of the proposed action that may include notice that the Provider may have the right to request a hearing or review within 30 days of receipt of the notice, and that the hearing must be held within 30 days after the date of receipt of a request for a hearing. If the Provider fails to request a hearing within the specified period, this shall constitute a waiver of the right for a hearing.

The review will be conducted before a hearing panel. The panel shall be appointed by the medical director and be comprised of three or more persons, at least one-third of whom may be clinical peers in the same discipline with a same or similar specialty as the Provider under review.

Following a hearing, the hearing panel shall render a decision on the proposed action within 10 business days. Decisions of the hearing panel may include reinstatement, provisional reinstatement with specified conditions or termination. Such a decision shall
be provided in writing to the Provider. A decision to terminate shall be effective no less than 30 days after receipt by the Provider of the hearing panel’s decision, or 60 days from the receipt of the notice of termination.

**Non-Renewals or Voluntary Terminations**
Either WellCare or a Provider may exercise a right of non-renewal at the expiration of the contract period with 60 days written notice or as otherwise specified in the Provider contract. In the case of Provider contracts without a specific expiration date, either party may exercise a right of non-renewal on each January 1 occurring after the contract has been in effect for at least one year or as otherwise specified in the Provider contract.

Notification of non-renewal to Providers will contain an explanation of the right of non-renewal, the time frames involved, and verification that non-renewal does not constitute termination. The Provider shall remain obligated to provide continuing care to Members currently receiving treatment for the term of the notice. Under certain circumstances, authorization may be obtained for continued care beyond the effective date of the end of the Provider’s affiliation with WellCare.

**Participating Provider Appeal through the Dispute Resolution Peer Review Process**
WellCare may immediately suspend, pending investigation, the participation status of a participating Provider who, in the opinion of the medical director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of Members. In such instances, the medical director investigates on an expedited basis.

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

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

The practitioner may also have 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. The second level panel is comprised of individuals who were not involved in earlier decisions.

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

- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service
- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct, service or excessive claims and/or sanction history
Notification of the adverse recommendation, together with reasons for the action, and the practitioner’s rights and process for obtaining the first and/or second-level dispute resolution peer review panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight recorded or certified return-receipt mail.

The practitioner has a period of up to 30 days in which to file a written request via recorded or certified return receipt mail to access the dispute resolution peer review panel process.

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

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

The dispute resolution peer review panel shall consider and decide the case objectively and in good faith. The medical director, within five business days after final adjournment of the dispute resolution peer review panel hearing, shall notify the practitioner of the results of the first level panel hearing. In the event the findings are positive for the practitioner, the second-level review shall be waived.

In the event the findings of the first level panel hearing are adverse to the practitioner, the practitioner may have the opportunity to access the second-level peer review panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first-level peer review panel.

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

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

A practitioner who fails to request the Provider dispute resolution peer review process within the time and in the manner specified waives any right to such review to which she or he might otherwise have been entitled. WellCare may proceed to implement the termination and make the appropriate report to the National Practitioner Data Bank and state licensing agency as appropriate and if applicable.

**Delegated Entities**
All Participating Providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored periodically and formal
audits are conducted annually. Please refer to Section 9: Delegated Entities in this Provider Manual for further details.
Section 7: Appeals and Grievances

Appeals

**Provider Appeals Overview**
A Provider may request an appeal regarding Provider payment, contractual issues, or a utilization review retrospective denial on his or her own behalf by mailing or faxing a letter of appeal and/or a **Provider Appeal Request form** with supporting documentation such as medical records to WellCare. The **Provider Appeal Request form** is available on WellCare’s website at www.wellcare.com/New-York/Providers/Medicaid/Forms.

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

Upon receipt of all required documentation, the initial decision/denial will either be reversed or affirmed. WellCare has 30 calendar days to review the case for Medical Necessity and conformity to WellCare guidelines.

Required documentation includes the Member’s name and/or identification number, date of services, and reason why the Provider thinks the decision should be reversed should be submitted with your request for appeal. 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 may be denied for lack of information. It is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the denial to 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 prohibited from charging WellCare or the Member for copies of medical records provided for this purpose.

**Provider Appeal 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. If a claim has been previously submitted and denied, it will be adjusted
for payment after the decision to reverse the denial has been made. WellCare will ensure that claims are processed and comply with the federal and state requirements.

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 affirmed. 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 notification 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 Department address listed in the decision letter.

Member Appeals Process

Overview
A plan appeal is a formal request from a Member to seek a review of an action taken by WellCare. A plan appeal may also be filed on the Member’s behalf by an authorized representative or a Provider acting on behalf of the Member. All plan 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.

To request a plan appeal of a decision made by WellCare, the Member may file a plan appeal request either orally or in writing within 60 calendar days of the date on the Notice of Action. If a standard appeal is filed orally via the WellCare Customer Service Department by calling 1-800-288-5441, the request must be followed up with a written, signed appeal to WellCare within 10 calendar days of the oral filing. For oral filings, the time frame for resolution begins on the date the oral filing was received by WellCare, once written confirmation is received. The review time frame begins upon first receipt of appeal, whether filed orally or in writing.

A Member filing an action appeal within 10 business days of the notice of action or by the intended date of an action, whichever is later, that involves the reduction, suspension, or termination of previously approved services may request aid continuing (continuation of benefits).

Examples of actions that can be appealed include, but are not limited to, the following:
- The denial or limited authorization of a service authorization request, 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
- Failure to provide services in a timely manner as defined by applicable state law and regulation
- Failure of WellCare to act within the time frames for resolution and notification of determinations regarding complaints, action appeals and complaint appeals
- In rural areas, as defined by 42 CFR § 412.62(f)(a), where enrollment in a managed care plan is mandatory and WellCare is the only managed care organization, the denial of a Member’s request to obtain services outside the WellCare’s network pursuant to 42 CFR § 438.52(b)(2)(ii)
• For Healthy Choice Members, an activity of WellCare or its subcontractors that results in the restrictions of a Member to certain network Providers under WellCare’s contract with the State of New York

Members will be provided reasonable assistance in completing forms and other procedural steps for an appeal, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD capability.

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

Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

WellCare will not take or threaten to take any punitive action against any Provider acting on behalf or in support of a Member requesting an appeal or an expedited appeal. In addition, WellCare will not terminate or refuse to renew a contract solely for the following:

- Advocating on behalf of a Member
- Filing a complaint against WellCare
- Appealing a decision made by WellCare
- Providing information or filing a report pursuant to PHL4406-c regarding prohibitions of WellCare
- Requesting a hearing or review

Appointment of Representative
If the Member wishes to use a representative, then she or he must complete an Appointment of Representative (Non-Medicare) (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/New-York/Providers/Medicaid/Forms.

Types of Appeals
If WellCare issues a denial for a request for services or for services rendered, the Member may file a request for an appeal determination. The request can also come from the Provider or office staff working on behalf of the Provider.

There are two types of appeals:

- Those that do not require medical review to determine necessity (non-utilization review) e.g. not a covered service or otherwise outside of the Member’s Benefit Plan
- Those appeals that require medical records review to determine Medical Necessity (utilization review)
The request for a plan appeal may be processed either as a standard or as an expedited appeal under their respective time frames.

Plan appeal requests for services already rendered are not eligible to be processed as an expedited appeal.

**Standard Appeals**

Upon receipt of the plan appeal request, WellCare will send a letter to the Member or the Member’s representative within 15 days acknowledging receipt of the appeal request.

A free copy of the appeal file along with medical records will be sent to the member and any other information used prior to the appeal decision being made. A member may also request to review their case file. If the Plan Appeal is fast tracked, there may be a short time to review this information.

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. In addition, before and during the appeal review, the Member or Member’s representative may review the case file.

If additional information is required to conduct a standard appeal, WellCare will notify the Member and the Member’s Provider in writing within 15 days of the receipt of the appeal, to identify and request the necessary information.

In the event that only a portion of such necessary information is received, WellCare will request the missing information in writing within five business days of receipt of the partial information.

If the Member’s request for appeal 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 following:

- The Member did not personally receive the adverse organization determination notice or received the notice late
- The Member was seriously ill, which prevented a timely appeal
- There was a death or serious illness in the Member’s immediate family
- An accident caused important records to be destroyed
- Documentation was difficult to locate within the time limits
- The Member had incorrect or incomplete information concerning the appeal process

**Resolution Time frame of a Standard Appeal**

For resolution of a standard appeal, WellCare will resolve the appeal and provide written notice to the parties involved as expeditiously as the Member’s health condition requires but no more than 30 days from the time WellCare receives the appeal.

**Expedited Appeals**

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

The health care Provider thinks an immediate appeal is warranted.

If the Member appeals a denial for continued or extended health care services, procedures or treatments, or for additional services for a Member undergoing a course of continued treatment, then the appeal will be automatically processed as an expedited appeal.

Upon request, a clinical peer reviewer will be available to speak with the requesting Provider within one business day following the request for an expedited appeal.

If additional information is required to conduct an expedited appeal, WellCare will immediately notify the Member and the Member’s Provider by telephone and/or facsimile to request the necessary information followed by written notification.

**Resolution Timeframe of an Expedited Appeal**

For resolution of an expedited appeal, WellCare will resolve the appeal to the parties involved as expeditiously as the Member’s health condition requires, but within two business days from receipt of the appeal request, but no more than 72 hours from the time WellCare receives the appeal if additional information was required. Written notice will be issued within 24 hours from the appeals determination.

In each instance, WellCare will make reasonable efforts to provide verbal notice to the Member with the appeal determination at resolution but not more than 72 hours.

Members who orally request an expedited appeal are not required to submit a written appeal request as outlined in the standard appeals section.

If the expedited utilization review appeal is not resolved to the satisfaction of the Member, the Member has the right to submit an appeal to WellCare that will be processed under standard timeframes or submit an appeal through the external appeal process.

**Denial of an Expedited Appeal Request**

WellCare will provide the Member with prompt oral notification within 24 hours regarding the denial of a request to process an appeal under expedited time frames and the Member’s rights, and will subsequently mail a letter to the Member within two calendar days of the oral notification that explains:

- That WellCare will automatically transfer and process the request using the 30 calendar day time frame for standard appeals beginning on the date WellCare received the original request.
- The Member’s right to file an expedited grievance if he or she disagrees with WellCare’s decision not to expedite the appeal and provide instructions about the expedited grievance process and its time frames.

**Extension of Standard and Expedited Appeal Determination Timeframes**

Review determination time frames may be extended by up to 14 calendar days if the Member requests an extension or if WellCare justifies a need for additional information and documents how the extension is in the interest of the Member. If an extension is not
requested by the Member, WellCare will provide the Member with prompt oral notice of the extension and will also provide written notice of the reason for the delay within two calendar days of the decision to extend the time frame.

**Member Appeal Decisions**

Members will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called an **Final Adverse Determination.**

Written notification of the appeal determination will be sent to the Member or the Member’s representative and Provider within two business days of when the appeal decision was made but not to exceed the 30 calendar days to process a standard appeal.

WellCare will authorize or provide the disputed services promptly and as expeditiously as the Member’s health condition requires, if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services. WellCare will also pay for the disputed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

If WellCare affirms its initial action and/or denial (in whole or in part), it will issue a notice of final adverse determination. Each notice of final adverse determination will be in writing and will be issued within two business days of when the appeal decision was made but not exceed 30 calendar days from the receipt of the appeal. The notice will include the date and:

- The basis and clinical rationale for the determination
- The words “final adverse determination”
- WellCare’s contact person and telephone number
- The Member coverage type
- The name and address of the utilization review specialist, contact person and telephone number
- The health service denied, including facility or Provider and developer or manufacturer of service as available
- A statement that the Member may be eligible for an external appeal and timeframes for such appeal; and if the appeal was expedited, a statement that the Member may choose to file a standard action appeal with WellCare or file an external appeal
- A statement that the Member may file a State Fair Hearing, which must be made within 120 days of the initial action notice Member
- An attachment with a standard description of the external appeals process
- A summary of the appeal and date filed
- The date the appeal process was completed
- A description of the Member’s Fair Hearing rights along with a fair hearing form
- A statement on the right of the Member to complain to the DOH at any time with the respective toll-free number
- A statement that the notice is available in other languages and formats for special needs Members and how to access these resources
- Notification that the Member will receive copies of all documents relevant to the Member’s standard action appeal free of charge
If WellCare modifies its original action in any way the notice of final adverse
determination will include the above information as well as the following:
- The appeal determination constitutes a new action
- A statement that the Member may file a State Fair Hearing request which must
  made within 120 days of the date of the notice of final adverse determination
- A managed care action taken notice

If WellCare does not make a decision within the applicable timeframes for Utilization
Reviews(UR), it will be deemed to be a reversal of WellCare’s initial adverse
determination.

**Fair Hearing for Members**
Members enrolled in Healthy Choice may request a fair hearing from New York State when:
- The Member is not happy with a decision his or her local department of social
  services or the state Department of Health made about staying or leaving
  WellCare.
- The Member is not happy with a Final Adverse Determination decision that
  WellCare made about medical care he or she was receiving.
- The hearing must be requested within 120 days.
- The Member gets a Final Adverse Determination that reduces, suspends, or
  stops care they are getting now, the member can continue to get the services
  their doctor ordered while waiting for the Fair Hearing to be decided. The
  Member must ask for a fair hearing within 10 days from the date of the Final
  Adverse Determination or by the time the action takes effect, whichever is later.
- The Member thinks the decision limits his or her Medicaid benefits or that
  WellCare did not make the decision in a reasonable time.
- The Member is not happy about a decision WellCare made about denied medical
  care he or she wanted.
- If Member does not receive a response to their Plan Appeal or a decision is not
  made in time, including extensions.
- The Member is not happy with a decision made to restrict their services. The
  member has 60 calendar days from the date of the Notice of Intent to Restrict to
  ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of
  Intent to Restrict, or by the effective date of the restriction, whichever is later, you
  can continue to get your services until the Fair Hearing decision.
- The Member is not happy with WellCare’s decision to agree with the decision
  that his or her doctor made not to order services he or she wanted and thinks the
  doctor’s decisions stops or limits his or her Medicaid benefits.
- The member will get an evidence packet including the information used to make
  the decision.

Parties to the Medicaid Fair Hearing include WellCare, as well as the Member and his or
her representative or the representative of a deceased Member’s estate. A Provider can
be a representative or a witness in a hearing process.

To request a Fair Hearing, Members may call the Office of Administrative Hearings
(OAH) at 1-800-342-3334 or visit the website at otda.ny.gov/hearings/
WellCare will continue the Member's benefits while the Medicaid Fair Hearing is pending if:

- WellCare has or is seeking to reduce, suspend or terminate a treatment or benefit package service currently being provided
- The Member has filed a timely request for a fair hearing with OAH
- There is a valid order for the treatment or service from a participating Provider

WellCare will provide aid continuing until the matter has been resolved to the Member's satisfaction, until the administrative process is completed and there is a determination from OAH that the Member is not entitled to receive the service; the Member withdraws the request for aid continuing and/or the fair hearing in writing; or the treatment or service originally ordered by the Provider has been completed, whichever occurs first.

WellCare will authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, if the services were not furnished while the Medicaid Fair Hearing was pending and reverses a decision to deny, limit or delay services.

WellCare will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Administrative Law Hearing was pending and reverses a decision to deny, limit or delay services. At the discretion of DOH, the Member may be liable for the cost of continued benefits if WellCare’s action is upheld.

Remember, Members and Providers can file a complaint at any time to the DOH by calling 1-800-206-8125. In some cases, Members can continue to receive care while they wait for a fair hearing.

If, at the Member's request aid continuing or, WellCare continues or reinstates the Member’s benefit while the Fair Hearing is pending, the benefits will be continued until one of the following occurs:

- The Member withdraws the appeal or request for the Medicaid Fair Hearing
- Ten business days pass after WellCare mails the notice of adverse action, unless the Member, within 10 business days, has requested a Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached
- A Fair Hearing officer issues a hearing decision adverse to the Member
- The time period or service limits of a previously authorized service has been met

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

**External Appeal**

The Member, the Member’s designee and, in connection with retrospective adverse determinations, a Member’s health care Provider acting on behalf of the Member, has the right to request an external appeal within four months when WellCare issues a final adverse determination.

The Member and WellCare may jointly agree to waive the internal appeal process. If this occurs, WellCare shall produce a written letter with information regarding filing an
An external appeal may be filed when:

- A Covered Health Care Service was denied on appeal, in whole or in part, on the grounds that such health care service was not Medically Necessary
- WellCare has rendered a final adverse determination with respect to such health care service
- Both WellCare and the Member have jointly agreed to waive any internal appeal
  - The Covered Health Care Service was denied on the basis that such service is experimental or investigational, and such denial has been upheld on internal appeal or both WellCare and the Member agree to waive the internal appeal process
  - And the Member’s attending physician has certified that the Member has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by WellCare; or (c) for which there exists a clinical trial, and
- And the Member’s attending Provider, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to the condition or disease, recommended either (a) a health service or procedure [including a pharmaceutical product within the meaning or PHL 4900(5)(b)(B)] that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the Member than any covered standard health service or procedure; or (b) a clinical trial for which the Member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and
- The specific health service or procedure recommended by the attending Provider would otherwise be covered under the policy except for the health care plan’s determination that the health service or procedure is experimental or investigational.
- WellCare has issued an out-of-network service denial

In order to be eligible for an external appeal, Providers appealing on their own behalf, must complete an external appeal application and submit it to the New York State Insurance Department within 60 days of the date of the final adverse determination from WellCare. New York external review is not available if the Member is covered under a Medicare managed care plan or a self-insured plan.

WellCare’s initial adverse determination, the notice of final adverse determination from WellCare, the fee (if required by the health plan), and the Member’s signed consent must be included with the application.

The application must be sent by certified or registered mail to:

New York State Department of Financial Services
PO Box 7209
Albany, NY 12224-0209
To obtain a copy of the application, or for more information, contact the Insurance Department at 1-800-400-8882 or visit their website at www.dfs.ny.gov.

A Provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of WellCare. WellCare is responsible for the full cost of an appeal that is reversed. The Provider and WellCare must evenly divide the cost of a concurrent adverse determination that is reversed in-part.

In addition, a Provider requesting an external appeal of a concurrent adverse determination, including a Provider requesting the external appeal as the Member's designee, is prohibited from seeking payment, except applicable co-pays, from a Member for services determined not Medically Necessary by the external appeal agent.

Grievances

**Provider**
Providers do not have grievance rights.

**Member**
The Member may file a complaint. A complaint may also be filed on the Member's behalf by an authorized representative or a Provider with the Member's written consent. All complaint 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 an Appointment of Representative (AOR) statement. Examples of complaints that can be submitted include, but are not limited to:

- **Provider Services including, but not limited to:**
  - Rudeness by Provider or office staff
  - Failure to respect the Member's rights
  - Failure to order a requested service
  - Quality of care/services provided
  - Refusal to see Member (other than in the case of patient discharge from office)
  - Office conditions
  - Discrimination

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

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

A Member, designee or any Provider acting on behalf of the Member with written consent may file a standard and/or expedited complaint at anytime from the date that caused the dissatisfaction.
WellCare will ensure that no punitive action is taken against a Provider who, as an authorized representative, files a complaint on behalf of a Member, or supports a complaint filed by a Member. Documentation regarding the complaint will be made available to the Member, if requested.

If the Member wishes to use a representative, she or he must complete an Appointment of Representative (AOR) statement. For more information, see the Appointment of Representative section above.

Complaint Submission
An oral complaint request can be filed, toll-free, by calling the WellCare Customer Service Department 1-800-288-5441. An oral request may be followed up with a written request by the Member, but the timeframe for resolution begins the date the oral filing is received by WellCare. A written complaint may be filed by mail to:

WellCare Grievance Department
PO Box 31384
Tampa, FL 33631-3384

Alternatively, the complaint may be faxed to 1-866-388-1769.

WellCare will acknowledge the Member’s standard complaint in writing within 15 business days from the date the complaint is received by WellCare. The acknowledgement letter will include:
- Name and telephone number of the grievance coordinator
- Request for any additional information, if needed to investigate the issue

For more information on how to contact the Grievance Department, refer to the Quick Reference Guide on WellCare’s website.

Grievance Resolution
Upon the determination of the complaint, a letter will be mailed to the Member. Complaints shall be resolved within 45 days after the receipt of all necessary information and no more than 60 days from receipt of the complaint.

When a delay would significantly increase the risk to a Member’s health, complaints shall be resolved within 48 hours after receipt of all necessary information and no more than seven days from the receipt of the complaint. The resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent, then one letter shall be sent that includes the acknowledgement and the decision of the grievance.

The resolution letter will include:
- The detail results/findings of the resolution
- All information considered in the investigation of the grievance
- The date of the grievance resolution
- In cases where the determination has a clinical basis, the clinical rationale for the determination
- The procedures for filing an appeal of the determination and the right of the Member to contact the State Department of Health regarding their complaint.
Complaint Appeal for Members

If the Member is not satisfied with the determination on the complaint, he or she will have no more than 60 business days after receiving the determination letter to file an appeal. The complaint appeal must be submitted in writing. The Member can write a letter or use WellCare’s complaint appeal form and submit it to:

WellCare Grievance and Appeal Department
PO Box 31384
Tampa, FL 33631-3384
or Fax the Appeal: 1-866-388-1769

Members may call the WellCare Customer Service Department for assistance at 1-800-288-5441.

An acknowledgment letter will be mailed to the Member within 15 business days of receiving the appeal. The letter will include:
- WellCare’s contact on the appeal
- How to reach this person
- If further information is needed

After WellCare receives all of the information needed:
- WellCare will render a determination within two business days when a delay would risk the health of the Member
- For all other complaint appeals, WellCare will render a decision in writing within 30 business days

WellCare will provide reasons for its decision and the clinical rationale, if it applies. If the Member still is not satisfied, he or she can file a complaint with the New York State Department of Health at 1-800-206-9125 or the local department of social services. The Member can also write to:

New York State Department of Health
Coming Tower, Empire State Plaza
Albany, NY 12237

If a Member is dissatisfied with the grievance decision reached by WellCare, the Member may file a complaint anytime by contacting the New York State Department of Health.
Section 8: Compliance

WellCare’s Compliance Program

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, its employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All Providers, including Provider employees and sub-contractors 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:

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

- Fraud, Waste and Abuse (FWA) Training
  - Must include, but is not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e. False Claims Act, Anti-Kickback statute, HIPAA, etc.)
    - Obligations of the Provider, including Provider employees and Provider sub-contractors and their employees, to have appropriate policies and procedures to address fraud, waste, and abuse
    - Process for reporting suspected fraud, waste and abuse
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse
    - 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 fraud hotline at 1-866-678-8355.

Details of the corporate ethics and compliance program are on WellCare’s website at www.wellcare.com/New-York/Corporate/Compliance.

Provider Education and Outreach

Providers may:
- Display state-approved health-plan specific materials in-office
- Announce a new affiliation with a health plan
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers, and print advertisement
Providers are prohibited from:

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

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.


**Code of Conduct and Business Ethics**

**Overview**

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

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

**Fraud, Waste and Abuse**

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

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

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

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

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

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

Every Provider practice is required to provide Members with a Notice of Privacy Practices (NPP). The NPP advises Members how the Provider practice may use and
share a Member’s PHI and how a Member can exercise his or her health privacy rights. HIPAA provides for the release of Member medical records to WellCare for payment purposes and/or health plan operations. HIPAA regulations require each covered entity, such as health care Providers, to provide an NPP to each new patient or Member.

Some examples of confidential information include:

- Medical records
- Communication between a Member and a Provider regarding the Member’s medical care and treatment
- All personal and/or 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

No health care Provider may be penalized for considering, studying or discussing Medically Necessary or appropriate care with, or on behalf of, his or her patient.

Confidentiality of HIV-Related Information in the Medical Record
To ensure confidentiality of HIV related information, Providers should have policies and procedures to address:

- Initial and annual in-service education of staff and contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for HIV-related information
- Protocols to protect persons with or suspected of having HIV from discrimination

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 the WellCare Customer Service Department using the toll-free number found on the Member’s ID card. Providers may contact the WellCare Provider Services Department by referring to the Quick Reference Guide on WellCare’s website.

Mandatory Compliance Certification
New York Medicaid providers who are required to have a compliance program must complete the SSL Certification. The SSL Certification requires Medicaid providers to certify that their compliance program has been adopted, implemented, and meets the requirements of SSL 363-d and 18 NYCRR Part 521. The SSL Certification must be completed using one of the five certification categories listed on the form, specifically:
1. Annual Certification;
2. Enrolling Provider Certification;
3. Revalidating Provider Certification;
4. Certification After Correcting Insufficiencies Identified in a Compliance Program Review; or
5. Certification After Receiving Notice of Regulatory Action for Failing to Complete Your Annual Certification.

Some Medicaid providers may be subject to the federal Deficit Reduction Act of 2005 (DRA) that is codified in 42 USC § 1396a(a)(68). These providers must annually complete what is referred to as the “DRA Certification.” The SSL Certification and the DRA Certification are separate certifications that require Medicaid providers to certify to different obligations and each establishes different criteria for their respective obligations. Some providers of Medicaid care, services, or supplies may be required to complete both certifications. **Certifications can only be submitted electronically at the New York Office of Medicaid Inspector General website.**

**Who Must Have a Compliance Program?**

Persons, providers, or affiliates are required to have a compliance program under New York State Social Services Law (SSL) § 363-d and 18 NYCRR Part 521 if they are a “required provider” as defined in 18 NYCRR § 521.2(a).

If you answer **YES** to any of the following questions, you are required to have a compliance program in New York State.

- Is your organization subject to Article 28 or Article 36 of the NYS Public Health Law?
- Is your organization subject to Article 16 or Article 31 of the NYS Mental Hygiene Law?
- Does your organization claim or order — and/or can be reasonably expected to claim or order — Medicaid services or supplies of at least $500,000 in any consecutive 12-month period?
- Does your organization receive Medicaid payments — and/or can be reasonably expected to receive payments — either directly or indirectly, of at least $500,000 in any consecutive 12-month period?

**Indirect Medicaid reimbursement** is any payment that you receive for the delivery of Medicaid care, services, or supplies that comes from a source other than the State of New York. For example, if you provide covered services to a Medicaid beneficiary who is enrolled in a Medicaid Managed Care Plan, the payment you receive from the Managed Care Organization is considered an indirect payment.

- Does your organization submit Medicaid claims of at least $500,000 in any consecutive 12-month period on behalf of another person or persons?

To complete the Certification or for additional information, Providers can visit the New York Office of Medicaid Inspector website at [https://omig.ny.gov/compliance](https://omig.ny.gov/compliance).
Section 9: Delegated Entities

Overview
WellCare’s compliance responsibilities extend to entities (“Delegated Entities”) that, by written contract, perform functions or services on behalf of WellCare (“Delegated Activities”). While certain activities may be delegated, WellCare is ultimately responsible and accountable to federal and state agencies for all services performed by its Delegated Entities. Delegated entities are expected to follow WellCare’s process for authorization or a process approved by WellCare. Refer to Section 4: Utilization Management for additional information. It is the ultimate responsibility of WellCare to monitor and evaluate the performance of the Delegated Activities to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and WellCare policies and procedures.

WellCare may require a corrective action plan or quality improvement plan if the Delegated Entity’s performance is unsatisfactory. The delegated entity must cooperate with WellCare and work diligently and continuously to implement any corrective action plan or quality improvement plan required by WellCare to WellCare’s satisfaction.

Compliance
WellCare’s compliance responsibilities extend to Delegated Entities, including, without limitation, maintaining and complying with:

- A compliance plan
- HIPAA privacy and security policies and procedures
- Fraud, Waste and Abuse training and reporting
- A cultural competency plan
- A disaster recovery and business continuity policy and procedure

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

WellCare ensures compliance of Delegated Entities through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC or the corporate Delegation oversight associates:

- 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 Delegated Activities that are delegated to the Delegated Entity and retained by WellCare, and reporting requirements in a clear and understandable manner in compliance with accreditation standards, all applicable state and federal laws, rules and regulations, and governmental agency requirements
- Ensure that the appropriate WellCare associates have properly evaluated the entity’s ability to perform the Delegated Activities prior to delegation
- Provide audits, which may at WellCare’s discretion be on-site, and ongoing monitoring of the Delegated Entity’s performance at least annually, including evaluation to ensure that quality of care and quality of service are 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
• Ensure the Delegated Entity is in compliance with federal regulations, including without limitation, the requirements in 42 CFR § 438
• Delegation Agreements, include, but are not limited to the following, provides that:
  o Comply with the New York contract and incorporate its applicable provisions.
  o Incorporate all the applicable accreditation standards, such as NCQA.
  o Provide for WellCare to audit and monitor the Delegated Entity’s performance on an ongoing basis, including those that are accredited; the frequency and method of reporting to WellCare, the process by which WellCare evaluates the Delegated Entity’s performance according to a periodic schedule consistent with industry standards, but no less than annually.
  o Provide a process for the delegated subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.
  o Specify the remedies up to and including, revocation of the some or all of the Delegated Activities and/or the delegation agreement available to WellCare if the Delegated Entity does not fulfill its obligations
  o Incorporate all applicable state and federal requirements, including 42 CFR 434.6 appropriate to the Delegated Activities
  o Require that the Delegated Entity fully adhere to the privacy, confidentiality, and other related requirements stated in the New York contract and in applicable federal and state laws, rules and regulations
  o Require that the Delegated Entity notify WellCare of all breaches of confidential information relating to any WellCare Member.
  o Require that the Delegated Entity, when applicable, submit encounter records in the format specified by MQD so that WellCare can meet the State’s specifications required by the State contract.
  o Specify that a Delegated Entity with NCQA®, URAC, or other national accreditation shall provide WellCare with a copy of its current certificate of accreditation together with a copy of the survey report.
  o Contain provisions that suspected fraud and abuse be reported to WellCare.
Section 10: Behavioral Health

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

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

Some behavioral health services may require Prior Authorization, including those services provided by non-participating Providers.

For complete information regarding benefits, exclusions and authorization requirements, or in the event a Provider needs to contact the WellCare Provider Services Department for a referral to a behavioral health Provider, refer to the Quick Reference Guide on WellCare’s website.

Continuity and Coordination of Care Between Medical and Behavioral Health Care

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 most recent version of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classification when assessing the Member for behavioral health services and document the ICD/DSM 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 PCPs at the time of discharge from an inpatient hospitalization (WellCare recommends faxing the discharge instruction sheet or a letter summarizing the hospital stay to the PCP). Please send this communication with the properly signed consent to the Member’s identified PCP noting any changes in the treatment plan on the day of discharge.

We strongly encourage open communication between PCPs and behavioral health Providers. If a Member’s medical or behavioral condition changes, WellCare expects that both the PCP and the behavioral health Provider 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 positively 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 appointment waiting times. The provisions below are applicable only to behavioral health Providers and do not replace the provisions set forth in Section 2: Provider and Member Administrative Guidelines for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health Provider – Emergent</td>
<td>&lt; 1 hour</td>
</tr>
<tr>
<td>Behavioral health Provider – Urgent</td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td>Behavioral health Provider – Post-inpatient discharge</td>
<td>&lt; 5 days</td>
</tr>
<tr>
<td>Behavioral health Provider – Routine</td>
<td>&lt; 2 weeks</td>
</tr>
<tr>
<td>Behavioral health Provider – Non-life threatening emergency</td>
<td>&lt; 6 hours</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. The specific time, date, place and name of the Provider to be seen must be provided to the Member. The outpatient treatment must occur within five 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 a 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 11: Pharmacy

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

- Preferred Drug List (PDL)
- Mandatory Generic Policy
- Recipient restriction program
- Coverage Determination Review Process
- Network Improvement Program (NIP)

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

- Follow national standards of care guidelines for treating conditions
- Prescribe drugs listed on the PDL
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class
- Evaluate medication profiles for appropriateness and duplication of therapy

To contact WellCare’s Pharmacy Services, please refer to the Quick Reference Guide on WellCare’s website.

Preferred Drug List
The PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmacy and Therapeutics Committee (P&T Committee).

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

The PDL can be found on our website at www.wellcare.com/New-York/Providers/Medicaid/Pharmacy. Any changes to the PDL and applicable pharmaceutical management procedures are communicated to Providers as the following:

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

Additions and Exceptions to the Preferred Drug List
To request consideration for inclusion of a drug to WellCare’s PDL, Providers may write to WellCare, explaining the medical justification. For contact information, refer to the Quick Reference Guide on WellCare’s website.
For more information on requesting exceptions, refer to the Coverage Determination Review Process below.

Coverage Limitations
WellCare covers all drug categories currently available through the New York Medicaid fee-for-service program. The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- Agents used for anorexia, weight gain or weight loss
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Non-prescriptive, over-the-counter (OTC drugs*) with a few exceptions listed on the PDL
- Drugs for the treatment of erectile dysfunction
- DESI drugs or drugs that may have been determined to be identical, similar or related
- Vitamin or mineral products, including prenataals or fluoride preparations (fluoride not covered over age 17), except for those listed on the PDL
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted

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

*All OTC drugs listed on the PDL as covered will require a prescription for the pharmacy to dispense.

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

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

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

Prior Authorization
Prior Authorization protocols are developed and reviewed at least annually by the P&T Committee. These protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). The criteria are available upon request when submitted to the Pharmacy Department by the Member or Provider.

Medications requiring Prior Authorization (PA) are identified on the PDL.
**Request timeframe:**
Prior authorization request must be processed within 24 hours. Immediate authorization for 72-hour emergency supply: immediate access to 5-day supply SUD treatment medication, immediate supply for opioid withdrawal/stabilization.

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

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven safe and cost-effective therapy is attempted before progressing to a more costly option. First-line medications are recognized as safe, effective and economically sound treatments. The first-line medications on our PDL have been evaluated through the use of clinical literature and are approved by the P&T Committee.

Medications requiring Step Therapy (ST) are identified on the PDL.

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

The PDL identifies medications with Quantity Limits (QL).

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

The PDL identifies medications with Age Limits (AL).

**Recipient Restriction Program**
WellCare will routinely review utilization data, such as encounter data, to assess and identify whether any Member appears to have a pattern of overutilization, underutilization or misutilization of services. This information will then be forwarded to the Recipient Restriction Program Review team for further review and final determination of restriction.

**Member Co-Payments**

**Child Health Plus**
There are no Member co-payments for prescribed legend or over-the-counter drug products.

<table>
<thead>
<tr>
<th>Program</th>
<th>Type of Medication</th>
<th>Co-payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Choice</td>
<td>Brand name drugs</td>
<td>$3</td>
</tr>
<tr>
<td>Healthy Choice</td>
<td>Generic drugs</td>
<td>$1</td>
</tr>
<tr>
<td>Healthy Choice</td>
<td>OTC drugs listed on the PDL</td>
<td>$0.50</td>
</tr>
<tr>
<td>Healthy Choice</td>
<td>Medical/diabetic supplies</td>
<td>$0</td>
</tr>
</tbody>
</table>

WellCare Health Plans, Inc.
New York Medicaid Provider Manual

Effective: July 31, 2019

Provider Services (toll free): 1-800-288-5441
Coverage Determination Review Process (Requesting Exceptions to the PDL)
The goal of the Coverage Determination Review program (also known as Prior Authorization) is to ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to Food and Drug Administration (FDA) approved indications. The Coverage Determination Process is required for:

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

Providers may request an exception to WellCare’s PDL orally or in writing. For written requests, Providers should complete a Prior Authorization Request Form for Prescriptions, supplying pertinent Member medical history and information. A Prior Authorization Request Form for Prescriptions may be accessed on WellCare’s website at www.wellcare.com/New-YorkProviders/Medicaid/Forms. There are additional Prior Authorization forms available based on the type of request or medication requested.

To submit a request, orally or in writing refer to the contact information listed on the Quick Reference Guide on WellCare’s website.

An approval decision is made upon receipt of the Prior Authorization Request Form for Prescriptions. If authorization cannot be approved or denied, and the drug is Medically Necessary, up to a seven-day emergency supply of the non-preferred drug shall be supplied to the Member if the pharmacy calls WellCare.

Durable Medical Equipment Supplies
All DME and medical supplies, including diapers, crutches, bandages, liquid nutritional supplements and other supplies will no longer be covered at the pharmacy. These items will need to be approved through the DME process. WellCare accepts requests by telephone or fax. Providers may call the WellCare Customer Service Department at 1-800-288-5441 or fax requests to 1-877-431-8859. Diabetic supplies will be covered at the pharmacy.

Medication Appeals
To submit a request to appeal a Coverage Determination Review decision, orally or in writing, Providers may refer to the contact information listed in the Quick Reference Guide on WellCare’s website.

Once the appeal of the Coverage Determination Review request decision has been properly submitted and obtained by WellCare, the request will follow the appeals process described in Section 7: Appeals and Grievances.
**Pharmacy Management - Network Improvement Program**

The Pharmacy Network Improvement Program provides Providers with quarterly utilization reports to identify over-utilization and under-utilization of pharmaceutical products. The reports will also identify opportunities for optimizing best practices guidelines and cost-effective therapeutic options. These reports are delivered by the State Pharmacy Director and/or Clinical Pharmacy Manager to physicians identified for the program.

**Member Pharmacy Access**

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

For areas where there are no pharmacies open 24 hours per day, Members may call CVS/Caremark for information on how to access pharmacy services. Contact information is located on the *Quick Reference Guide* on WellCare’s website.

**Exactus Pharmacy Solutions**

WellCare offers specialty pharmacy services to Members who are taking medications to treat long-term, life-threatening or rare conditions. The Exactus Pharmacy Solutions team are experts in the special handling, storage and administration that injectables, infusibles, orals, and other medications require. This team knows the insurance process and the Member’s plan benefits. This means less chance of delays in a Member receiving their needed medication(s). Prescription orders generally ship directly to the Member’s home, Provider’s office, or alternative address provided by the Member, within 24 to 48 hours after contacting an Exactus Pharmacy Solutions representative. The actual ship date depends on whether Provider discussion is needed about the prescription.

To learn more about the conditions covered under Exactus Pharmacy Solutions, or how to contact them, refer to WellCare’s website at [www.wellcare.com/New-York/Providers/Exactus-Specialty-Pharmacy](http://www.wellcare.com/New-York/Providers/Exactus-Specialty-Pharmacy).
Section 12: Definitions and Abbreviations

Definitions

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

**Action** means, pursuant to 42 CFR 438.400(b). the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; or the failure of WellCare to act within 90 days from the date WellCare receives a grievance, or 45 days from the date WellCare receives an appeal. For a resident of a rural area with only one managed care entity, the denial of a Member’s request to exercise the right to obtain services outside the network.

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

**Appeal** means a formal request from a Member to seek a review of an action taken by WellCare pursuant to 42 CFR 438.400(b).

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

**Behavioral Health** means services to address mental health disorders and/or chemical dependence.

**Benefit Plan** means a schedule of health care services to be delivered or other health covered service contract or coverage document issued by WellCare or administered by WellCare pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

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

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

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

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

**Clean Claim** means as defined in the participating provider agreement.

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

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

**Covered Services** means Medically Necessary items and services covered under a Benefit Plan.

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

**Emergency Condition** means as defined in the participating provider agreement.

**Emergency Services and Care** means as defined in the participating provider agreement.

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

**Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a Provider or WellCare employee or failure to respect the Member’s rights.

**Ineligible Person** means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG’s mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

**Medically Necessary** means as defined in the participating provider agreement.
**Member** means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

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

**Members/Individuals with Special Health Care Needs** means Members with special needs are defined as 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.

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

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

**Primary Care Provider (PCP)** means a qualified physician, or certified nurse practitioner or team of no more than four (4) qualified physicians/certified nurse practitioners which provides all required primary care services contained in the Benefit Package to Members.

**Provider or Participating Provider** means any physician, hospital, facility, ancillary or other health care professional or entity licensed or otherwise authorized to provide health care services in the state or jurisdiction and contracted with WellCare.

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

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

**Routine Care** means the level of care that can be delayed without anticipated deterioration in the Member’s condition.

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

**Urgently Needed Services** means covered services that are not Emergency Services as defined in this section, provided when a Member is temporarily absent from the Contractor’s service area, when the services are Medically Necessary and immediately required: (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the services through the Contractor’s MMC or FHPlus Participating Provider.

**WellCare Companion Guide** means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to WellCare or its Affiliates, as amended from time to time. The WellCare Claims/Encounter Companion Guides are part of the Provider Manual.
Abbreviations

AAP – American Academy of Pediatrics
ACIP – Advisory Committee on Immunization Practices
ACS – American College of Surgeons
AHP – Allied Health Professionals
AIDS – Acquired Immune Deficiency Syndrome
AL – Age limit
AMA – American Medical Association
ARNP – Advanced Registered Nurse Practitioner
ASAM – American Society for Addiction Medicine
BH – Behavioral Health
BMI – Body mass index
C/THP – Child/Teen Health Program
CAD – Coronary artery disease
CAP – Corrective action plan
CDS – Controlled Dangerous Substance
CHF – Congestive heart failure
CHP – Child Health Plus
CIA – Corporate Integrity Agreement
CLIA – Clinical Laboratory Improvement Amendment
CM – Care management / care manager
CMS – Centers for Medicare & Medicaid Services
CNM – Certified Nurse Midwife
COPD – Chronic obstructive pulmonary disease
CPGs – Clinical Practice Guidelines
CPT – Current procedural terminology
CRNA – Certified Registered Nurse Anesthetists
CSR – Controlled Substance Registration
DDE – Direct data entry
DEA – Drug Enforcement Administration
DHHS – United States Department of Health and Human Services
DM – Disease Management
DME – Durable medical equipment
DOH – New York State Department of Health
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOT</td>
<td>Directly observed therapy</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic data interchange</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
</tr>
<tr>
<td>EOP</td>
<td>Explanation of Payment</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis, and Treatment</td>
</tr>
<tr>
<td>FEP</td>
<td>First Episode Psychosis</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee for service</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>FTE</td>
<td>Full time equivalent</td>
</tr>
<tr>
<td>FWA</td>
<td>Fraud, waste, and abuse</td>
</tr>
<tr>
<td>H&amp;H</td>
<td>Hemoglobin and Hematocrit</td>
</tr>
<tr>
<td>HCBS</td>
<td>Home and Community Based Services</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HRA</td>
<td>Health risk assessment</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td><em>International Classification of Diseases, 10th Revision, Clinical Modification</em></td>
</tr>
<tr>
<td>ICD-10-PCS</td>
<td><em>International Classification of Diseases, 10th Revision, Procedure Coding System</em></td>
</tr>
<tr>
<td>IPA</td>
<td>Independent physician association</td>
</tr>
<tr>
<td>ISHCN</td>
<td>Individuals with Special Health Care Needs</td>
</tr>
<tr>
<td>IVR</td>
<td>Interactive voice response</td>
</tr>
<tr>
<td>JNC</td>
<td>Joint National Committee</td>
</tr>
<tr>
<td>LDSS</td>
<td>Local Department of Social Services</td>
</tr>
<tr>
<td>LOCADTR</td>
<td>Level of Care for Alcohol and Drug Treatment Referral</td>
</tr>
<tr>
<td>LTAC</td>
<td>Long term acute care</td>
</tr>
<tr>
<td>MAS</td>
<td>Medical Answering Services</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles/Mumps/Rubella</td>
</tr>
<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>NDC</td>
<td>National Drug Codes</td>
</tr>
</tbody>
</table>
TB – Tuberculosis
TIN/Tax ID – Tax Identification Number
UM – Utilization Management
VFC – Vaccines for Children
WEDI – Workgroup for Electronic Data Interchange
Section 13: WellCare Resources

WellCare of New York Main Page
www.wellcare.com/New-York

Provider Main Page
www.wellcare.com/New-York/Providers

Provider Manual and Quick Reference Guide
www.wellcare.com/New-York/Providers/Medicaid

Forms and Documents
www.wellcare.com/New-York/Providers/Medicaid/Forms

Pharmacy
www.wellcare.com/New-York/Providers/Medicaid/Pharmacy

Claims
www.wellcare.com/New-York/Providers/Medicaid/Claims

Clinical Practice Guidelines
www.wellcare.com/New-York/Providers/Clinical-Guidelines/CPGs

Clinical Coverage Guidelines
www.wellcare.com/New-York/Providers/Clinical-Guidelines/CCGs

Job Aids and Resource Guides
www.wellcare.com/New-York/Providers/Medicaid

Provider Training
www.wellcare.com/New-York/Providers/Medicaid/Training
Provider must be a registered user of WellCare’s secure online Provider Portal to access.
Addendum A: Behavioral Health Services

WellCare Members who were previously receiving behavioral health services using their Medicaid card will now access those services through WellCare.

Behavioral health care includes mental health and substance use (including alcohol and drugs) treatment and rehabilitation services. All WellCare Members have access to services to help with emotional health, or to help with alcohol or other substance use issues.

Behavioral Health Provider as a PCP
If a Member is using behavioral health clinic that also provides primary care services, he or she may select a lead Provider to be their PCP.

Appointment and Availability Times for Behavioral Health Services

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPEP</td>
<td>Immediate upon presentation</td>
</tr>
<tr>
<td>Inpatient mental health and inpatient detoxification substance use services</td>
<td></td>
</tr>
<tr>
<td>Crisis intervention services</td>
<td></td>
</tr>
<tr>
<td>Urgent:</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>- Substance use disorder inpatient rehabilitation services</td>
<td></td>
</tr>
<tr>
<td>- Stabilization treatment services in OASAS certified residential settings</td>
<td></td>
</tr>
<tr>
<td>- Mental health or substance use disorder outpatient clinics</td>
<td></td>
</tr>
<tr>
<td>- Assertive Community Treatment (ACT), Personalized Recovery Oriented</td>
<td></td>
</tr>
<tr>
<td>- Services (PROS)</td>
<td></td>
</tr>
<tr>
<td>- Opioid Treatment Programs</td>
<td></td>
</tr>
<tr>
<td>Non-urgent behavioral health specialist referrals for PROS programs other than clinic services</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Non-urgent behavioral health specialist referrals for:</td>
<td>Within 2-4 weeks</td>
</tr>
<tr>
<td>- CDT</td>
<td></td>
</tr>
<tr>
<td>- IPRT</td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation services for residential</td>
<td></td>
</tr>
<tr>
<td>- Substance use disorder treatment services</td>
<td></td>
</tr>
<tr>
<td>Type of Appointment</td>
<td>Access Standard</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>• Following an emergency</td>
<td>Within 5 days, or as clinically indicated</td>
</tr>
<tr>
<td>• Hospital discharge or release from incarceration, if known</td>
<td></td>
</tr>
<tr>
<td>• Follow-up visits with a behavioral health Participating Provider (as included in the benefit package)</td>
<td></td>
</tr>
<tr>
<td>Non-urgent mental health or substance use disorder visits with a Participating Provider that is a mental health and/or substance use disorder outpatient clinic, including a PROS with clinical treatment</td>
<td>Within 1 week</td>
</tr>
</tbody>
</table>

**Level of Care Guidelines**
WellCare uses the following guidelines for making Medical Necessity determinations associated with the following levels of care (LOC) and services:

<table>
<thead>
<tr>
<th>Level of Care / Service</th>
<th>Level of Care Guidelines / Criteria Used</th>
<th>Prior Authorization Required (Y/N)</th>
<th>Concurrent Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental health office and clinic services including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family/collateral, and group psychotherapy</td>
<td>InterQual (Mental Health) CCG - Outpatient Treatment for Mental Health and Substance Use Disorders HS-271</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychological or neuropsychological testing</td>
<td>InterQual (Mental Health) CCG-Use of Psychological and Neuropsychological Testing</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>PROS Admission: Individualized Recovery Planning</td>
<td>LOCUS (Mental Health)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>PROS Active Rehabilitation</td>
<td>LOCUS (Mental Health)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Service</td>
<td>Provider</td>
<td>Required</td>
<td>Covered</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td>Mental Health Continuing Day Treatment (CDT)</td>
<td>LOCUS (Mental Health)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Intensive Outpatient</td>
<td>InterQual (Mental Health)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Partial Hospitalization</td>
<td>InterQual (Mental Health)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Assertive Community Treatment</td>
<td>NYS ACT Program Guidelines <a href="http://www.omh.ny.gov/omhweb/act/program_guidelines.html">www.omh.ny.gov/omhweb/act/program_guidelines.html</a></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient office and clinic services provided by OASAS-certified agencies including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family/collateral, and group psychotherapy</td>
<td>LOCADTR (Substance Abuse)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Medically Supervised Outpatient Substance Withdrawal</td>
<td>LOCADTR (Substance Abuse)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Opioid Treatment Program (OTP) Services</td>
<td>LOCADTR (Substance Abuse)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Use Disorder Intensive Outpatient</td>
<td>LOCADTR (Substance Abuse)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Use Disorder Day Rehabilitation</td>
<td>LOCADTR (Substance Abuse)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Stabilization and Rehabilitation services for residential SUD treatment</td>
<td>LOCADTR (Substance Abuse)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Comprehensive Psychiatric Emergency Program (CPEP)/Inpatient Services</td>
<td>InterQual (Mental Health) Acute Psychiatric Inpatient Services CCG</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Service</td>
<td>InterQual (Mental Health)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Intensive Psychiatric Residential Treatment Services (IPRT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Crisis Intervention</td>
<td>N/A</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Medically Managed IP Withdrawal</td>
<td>LOCADTR (Substance Abuse)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Peer Supports</td>
<td>N/A</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

For additional information regarding level of care guidelines beyond the summary grid above, please refer to the following websites:

**InterQual Criteria:**

**OASAS LOCADTR Guidelines:**

**NYS OMH Policy Guidance:**
[omh.ny.gov/omhweb/bho/policy-guidance.html](http://omh.ny.gov/omhweb/bho/policy-guidance.html)

For OASAS Services, which require the use of LOCADTR, Providers and WellCare generally follow these steps:

- The WellCare Utilization Manager calls the Provider to discuss the Provider’s proposed LOC and clinical rationale used to make the LOC determination.
- If both parties still do not agree, the WellCare Utilization Manager arranges for a secondary review, which is to be a Peer-to-Peer review/discussion.
- If there still isn’t consensus, the Provider may request an Appeal of WellCare’s decision.

**Guidelines for Requesting Higher Level of Care (HLOC) Services**

For HLOC Services, WellCare uses McKesson InterQual™, Level of Care Utilization System (LOCUS) criteria and WellCare Clinical Coverage Guidelines (CCGs) as tools to assist in determining Medical Necessity for mental health and LOCADTR for all OASAS services.

**HLOC Definition:** This includes acute inpatient, crisis stabilization, partial hospitalization services and intensive outpatient programs as covered by the specific contract.

**Service Requests**

Providers can find the appropriate HLOC service request forms in our behavioral health section of the WellCare of New York website. Providers may fax these request forms 24/7 to the number assigned to your contract. Emergency Services do not require Prior Authorization, but notice is required to facilitate claims payments and determine ongoing treatment. Therefore, WellCare requests notice of all emergency services within 24 hours.
Please be certain that all the necessary information to complete the review has been provided. Incomplete or lack of adequate information will delay the response and in certain circumstances, may result in your request being denied.

**Inpatient Concurrent Review**

After the initial authorization is approved, concurrent review is needed for additional inpatient services. Inpatient concurrent review is done telephonically, though Providers may fax updated clinical information to be used in the review. The WellCare behavioral health licensed clinician will confirm admission data, discuss the plan of treatment, the discharge plan and any treatment barriers. Please be prepared to discuss the following data:

**Presenting Situation and Current Clinical Status, including:**
- Current precipitant, history of treatment
- Current mental status including risks and safety issues
- Diagnoses: Primary and Secondary diagnoses upon admission and changes
- Medical Issues
- Medications: (All) reasons, effects, side effects and changes
- Plan of treatment to stabilize the crisis, evaluation of changes implemented and effectiveness

**Living Situation and Family/Other Supports**

Where was the Member living, can he/she go back, the living situation and conditions, and what kind of support/influence the situation provided.

**Discharge Plan**
- The current discharge plan, with updates upon each review;
- Any barriers to discharge and what’s being done to resolve these issues;
- Summary of medications, including quantity provided, prescriptions given and affirmation that any Prior Authorizations for medications has been obtained
- A concrete final plan with specific follow-up appointments for medical/behavioral health support that meets requirements. NCQA standards are that appointments are made within seven days (within five days for NY Members)
- Within 24 hours of discharge, the Provider must fax the WellCare discharge form to the number indicated or call in the information to the designated staff member

**Guidelines for Submitting Outpatient Service Requests that require Prior Authorization**

The following tips and guidelines will assist Providers with submission of accurate and appropriate service requests that will be successfully approved.

- Number of requested services: Please ask for only the types and number of services you expect to need.
- Do not leave blanks on the form. Blanks are interpreted as an incomplete request, which will delay processing. Please indicate an answer that lets us know you reviewed each field and did not simply skip sections.
- In general, we are looking for strength-based, individualized, culturally competent, and medically integrated services that are designed to promote Recovery and Resiliency. Your answers on the form need to demonstrate how
you are doing that. For example, under Purpose of Treatment: "John needs individual counseling, skills building and assistance creating and maintaining an active support system to meet his goal of finding a job and moving to his own apartment."

- Axes I-V: Please complete all Axes. For Axis V, please indicate GAF or CAFAS as used by your state to show the overall functional rating of the Member.

**Treatment Goals**
- Must be individualized and should come directly from your treatment plan.
- It is always best if your treatment plan includes “I” statements from the Member about what they want to achieve.

**Guidance governing Service Authorization Determinations with OMH Clinic Standards of Care and OASAS Clinical Guidance incorporated**

**Handling of Emergency Behavioral Health Calls**
Behavioral health Providers are expected to assist Members in accessing emergent, urgent, and routine behavioral services as expeditiously as the Member’s condition requires. Members also have access to a toll free behavioral crisis hotline that is staffed 24 hours a day. The behavioral crisis phone number is printed on the Member’s card and is available on our website, and can be accessed by calling 1-855-582-6265.

WellCare Customer Service Representatives (CSRs) are trained evaluate the severity of the call and to listen for crisis warning signs. If a CSR suspects that the Member or another person is in danger or may commit suicide, the CSR is trained to obtain critical information, including the Member’s physical location, the phone number they are calling from and if the Member is alone.

The CSR makes every attempt to connect the Member to the BH Crisis Line or 911. If the Member refuses to get help from a BH representative, the CSR is trained to escalate the call and remain engaged with the Member as long as needed until help arrives.

Once the call has been connected, the CSR notifies a supervisor or manager and remains on the line until the clinician has given instructions to release the call. The call is also tracked in the WellCare CAREConnects program.

If the Member is connected to the BH Crisis Line, the BH clinician evaluates whether the circumstance warrants engagement with local mobile crisis responders or is emergent, and requires 911 dispatch. In the event that a mobile crisis responder or program is available and can be engaged, the BH clinician may connect the Member with a mobile crisis responder or program to assist the Member.

If the circumstance either becomes or is emergent, the BH clinician contacts 911 for immediate assistance, and remains on the line with the caller at all times.
For all Members who contact the crisis line in active crisis or if the crisis was resolved during the crisis call assessment are referred to WellCare’s internal case management program and are assigned to the behavioral health case manager. This case manager will outreach the Member to assess their needs and make additional applicable referrals based upon the Member’s unique needs to help achieve their crisis management and recovery goals.

**Emergency Services**

Emergency services, including CPEP, are not subject to prior approval. Crisis Intervention and OMH/ OASAS specific non-urgent ambulatory services are not subject to prior approval.

**Self-Referral**

There is no limit on self-referrals for behavioral health and substance use assessments (except for ACT, inpatient psychiatric hospitalization, partial hospitalization, HCBS services).

**Behavioral Health Quality Improvement Committee (BHQC)**

**Purpose:** WellCare of New York’s Behavioral Health Quality Improvement Committee (BHQC) oversees the quality management (QI) of Behavioral Health programs and reports regularly to the New York State Board of Directors. It is responsible for promoting our goals and objectives of our Behavioral Health program and its integration with medical programs. The BHQC is dedicated to promoting the goals and objectives of the Behavioral Health QI program through oversight and approval of all Behavioral Health QI activities. The BHQC is tasked with monitoring, assessing, evaluating and analyzing progress toward Behavioral Health QI goals; providing general direction and oversight for Behavioral QI activities; and recommending courses of action for improvement.

**Location:** The BHQC physically meets in New York, New York, and includes a teleconferencing option so that committee Members may attend meetings telephonically.

**Chairperson:** New York’s Behavioral Health Medical Director acts as the chairperson of the BHQC

**Additional Membership:** The Behavioral Health Medical Director, medical director, and QI Director collaborate to provide oversight of all Behavioral Health QI activities. The Behavioral Health QI Project Manager shall lead this committee meeting. Other committee Members include Member(s) having had a Behavioral Health diagnosis, family relatives of Member(s) having had a Behavioral Health diagnosis, peer specialists, and Behavioral Health Provider representatives. Other committee Members include Behavioral Health Case Management, Behavioral Health Provider Relations, QI staff, and other staff deemed appropriate.

**Credentialing Criteria for OMH-Licensed and OASAS Certified Behavioral Health Providers**

- When credentialing OMH-licensed, OMH-operated and OASAS-certified Providers, plan will accept OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors or agents of such Providers. The Contract shall collect and will accept
program integrity related information as part of the licensing and certification process.

- Plan requires that such Providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Confidentiality
Each healthcare Provider must develop policies and procedures to assure confidentiality of mental health and substance abuse related information. The policies and procedures must include:

- Initial and annual in-service education of staff and contractors
- Identification of staff allowed access and the limitations on that access
- Procedure to limit access to trained staff (including contractors)
- Protocols for secure storage (including electronic storage)
- Procedures for handling requests for behavior health and substance abuse information as well as protocols to protect persons with behavioral health and/or substance use disorder from discrimination

Provider Education and Training

The WellCare of New York BH Provider Training Plan outlines required Provider training topics, including Cultural Competency. The Provider Training Plan and all available BH Provider Training modules and supporting materials can be on the WellCare website at www.wellcare.com/New-York/Providers/Medicaid/Training.

Reporting to OMH and OASAS

WellCare of New York, Inc., has a policy that requires the plan to submit to OMH and OASAS a quarterly report of any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed certified or designated Providers. In addition, WellCare will report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

Identification and Prompt Referral of Individuals with First Episode Psychosis (FEP)

Members experiencing FEP have a diagnosis of schizophrenia (any type), psychosis, schizoaffective disorder, schizophreniform disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, other specified schizophrenia spectrum and other psychotic disorder or unspecified schizophrenia spectrum and other psychotic disorder. FEP generally occurs in individuals age 16-35 and are Members who have psychotic symptoms that have occurred within the previous two years and remain in need of mental health services. Members who experience FEP may also include Transition Aged Youth (TAY).

Members identified as experiencing FEP are to be promptly referred to appropriate network Providers and programs that can address the Member’s needs. This may include OnTrackNY teams, which offer recovery-oriented services such as case management for social and community needs, supported employment and education, FEP-relevant psychotherapy and support, pharmacotherapy and primary care.
coordination. OnTrackNY programs incorporate peer support and a staff-to-client ratio of approximately 1:10.

Current OnTrackNY sites include the following:

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<tr>
<th>Program</th>
<th>County</th>
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<tr>
<td>Washington Heights Community Service</td>
<td>Manhattan</td>
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<tr>
<td>North Shore/Long Island Jewish</td>
<td>Queens</td>
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<tr>
<td>Kings County Hospital Center</td>
<td>Kings</td>
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<tr>
<td>Mental Health Association of Westchester</td>
<td>Westchester</td>
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<tr>
<td>Catholic Charities of Broome County</td>
<td>Broome</td>
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<tr>
<td>Jewish Board of Family and Children Services</td>
<td>Manhattan</td>
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<tr>
<td>Bellevue Hospital Center</td>
<td>Manhattan</td>
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<tr>
<td>Parsons Northern Rivers</td>
<td>Rensselaer</td>
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<tr>
<td>Suffolk County Farmingville Clinic</td>
<td>Suffolk</td>
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<tr>
<td>Lakeshore Behavioral Health</td>
<td>Erie</td>
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<tr>
<td>Hutchings Psychiatric Center</td>
<td>Onondaga</td>
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<tr>
<td>Elmira Psychiatric Center</td>
<td>Chemung</td>
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<td>Chautauqua Tapestry</td>
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Providers may pursue additional FEP Provider training and resources through the Center for Practice Innovations (CPI), or on the CPI website at: [www.practiceinnovations.org/CPIInitiatives/OnTrackNY/tabid/202/Default.aspx](http://www.practiceinnovations.org/CPIInitiatives/OnTrackNY/tabid/202/Default.aspx)

WellCare of New York also offers a specific Provider training module on FEP, which can be found on the [www.wellcare.com/New-York/Providers/Medicaid/Training](http://www.wellcare.com/New-York/Providers/Medicaid/Training) website.

**Emergency Pharmacy Protocols for Enrollees with Behavioral Health Condition**

Except where otherwise prohibited by law:

- WellCare allows immediate access without Prior Authorizations to a 72-hour emergency supply of the prescribed drug or medication for an individual with a behavioral condition experiences an emergency condition as defined in the Contract
- Will immediately authorize a seven-day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization

**Ongoing Course of Care Policy**

WellCare will not deny coverage of an ongoing course of care unless an appropriate Provider of alternate level of care is approved for such care.

**Monitoring of Need for Care Management Services**

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 positively impact Member outcomes. This involves monitoring for a Member’s care management needs, including the review of Provider documentation for evidence of:
• HH/HCBS/HARP eligible triggers
• AOT orders (and encourage enrollment in a HARP if court order does not already require it)
• Frequent use of crisis/emergency departments
• Repeat admissions
• Crisis prevention plans
• Correctional system involvement
• Lack of treatment engagement
• Clinical appropriateness of care/effectiveness of treatment/evidenced based practices (EBP)
• Environmental/community/family/peer supports
• Assessment of tobacco use, education and referral
• Care gaps

Behavioral health utilization care managers have an active role during the utilization review process. They will evaluate and consider the above components during their concurrent review process and actively assist when clinically appropriate with:
• Care shaping
• Suggestion/reinforcement of Provider EBPs
• Suggestion of crisis plan development or revision of existing crisis plan
• Referrals to HH/HCBS/HARP and/or additional ancillary supports
• Discharge planning process

In addition to the above care management activities the BH UM care manager will identify and pursue opportunities to communicate with treating Providers regarding utilization review process, medical director peer-to-peer interactions, additional Member appropriate referrals/care coordination and case conferences (IDTs).

**Denial, Grievance and Appeal Decisions**

All denial, grievance and appeal decisions must be peer-to-peer and are subject to specific BH requirements including:
• A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment
• A physician certified in addiction treatment must review all inpatient level of care denials for SUD treatment

**Health Home Program**

It is WellCare’s policy to partner with New York’s Approved Health Homes in an effort to reduce the inappropriate utilization of Medicaid Covered Services by identifying and managing WellCare Members with a combination of medical and behavioral health diagnoses, through increased coordination of services performed by Health Homes and designated Care Management agencies. WellCare coordinates and co-manages the care of Members in the Health Home program by providing the Health Home with utilization data for Members assigned. This facilitates services intended to reduce the overutilization of behavioral health services, including substance and alcohol abuse. Members who are identified for participation in the Health Home Program are ensured access to Medically Necessary quality health care, while avoiding unnecessary costs to the Medicaid program.
It is expected that WellCare Providers work with both WellCare and Health Homes as an integrated team to carry out care management activities that require focus on Members with SMI, SUD, co-occurring physical health, co-occurring MH and/or SUD disorders and I/DD when appropriate.
Quality care is a team effort.
Thank you for playing a starring role!

www.wellcare.com/NewYork