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. Robert London
Chief Medical Officer
South Carolina

Partners in Quality Care

Quality care is a team effort.
Thank you for playing a starring role!
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Section 1: Welcome to WellCare

WellCare Health Plans, Inc., through its subsidiaries and affiliates, provides managed care services targeted exclusively to government-sponsored healthcare programs, focused on Medicaid and Medicare, including prescription drug plans and health plans for families, and the aged, blind and disabled. WellCare’s corporate office is located in Tampa, Florida. WellCare serves approximately 6.3 million Members.

WellCare of South Carolina, Inc. ("WellCare“ or “Health Plan”) is contracted with the South Carolina Department of Health and Human Services (SCDHHS) to provide Medicaid managed care services. WellCare’s experience and commitment to government-sponsored healthcare programs enable us to serve our Members and Providers as well as manage our operations effectively and efficiently.

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

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

Our values are:

- Partnership – Members are the reason we are in business; Providers are our partners in serving our Members; and regulators are the stewards of the public's resources and trust. We will deliver excellent service to our partners.
- Integrity – Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.
- Accountability – All associates must be responsible for the commitments we make and the results we deliver.
- One Team – 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 (“Manual”) is intended for WellCare’s in network Providers that deliver healthcare items and services to WellCare’s Members who are enrolled in a WellCare Medicaid Benefit Plan. This Manual serves as a guide of the policies and procedures governing the administration of WellCare’s Medicaid plans and is an extension of and supplements the network participation agreement (“Provider Agreement”) between WellCare and its healthcare Providers who participate in WellCare’s Provider networks (“Providers”) and may include, without limitation: physicians, hospitals and ancillary Providers. This Manual is effective August 12, 2019, and available on WellCare’s website at

________________________
WellCare of South Carolina, Inc.
Medicaid Provider Manual
Provider Services: 1-888-588-9842

Effective: August 12, 2019
Page 7 of 132
www.wellcare.com/South-Carolina/Providers/Medicaid. A paper copy may be obtained at no charge upon request by contacting Provider Services or a Provider Relations representative.

In accordance with the terms of your Provider Agreement with WellCare, Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to WellCare’s policies and procedures and shall become effective upon posting to our website or in accordance with the terms of your Provider Agreement. As policies and procedures change, and unless otherwise provided in the Provider Agreement, updates will be issued by WellCare in the form of Provider Bulletins that are posted to the Provider Portal on WellCare’s website; subsequent Manual updates that include a Table of Revisions; and quarterly Provider newsletters.

WellCare’s Medicaid Managed Care Plan
WellCare’s Medicaid managed care services allow flexibility and offer a distinct set of benefits to fit Members’ needs in South Carolina.

WellCare will ensure that no Member is denied the benefits of, or participation in, covered services on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated.

Eligibility
Eligibility for South Carolina’s Medicaid program is determined by the SCDHHS. This program is limited to certain Medicaid-eligible individuals who:

- Do not also have Medicare;
- Are under the age of 65;
- Are not in a nursing home;
- Do not have limited benefits such as family planning, specified low-income beneficiaries, emergency service only, etc.;
- Are not participating in a Home or Community-Based Waiver program;
- Are not participating in Hospice;
- Are not participating in the PACE program;
- Do not have a managed care organization through third-party coverage; or
- Are not enrolled in another Medicaid managed care plan.
- Are not otherwise excluded from participation based on federal requirements or state laws or policies

Infants and Medicaid Eligibility
An infant who is born to a Medicaid-eligible woman is “deemed” to be eligible for Medicaid and will continue to be eligible for Medicaid for one year after delivery, as long as the child remains a resident of the state. Eligibility continues without regard to income. A separate Medicaid application is not required. An infant born to a woman eligible for emergency services only may not be deemed, and a separate application and eligibility determination must be completed. SCDHHS cannot produce the infant’s Medicaid card without the child’s official name and correct date of birth. “Non-deemed
Infants” refers to infants who were not born to a Medicaid-eligible woman. An application and eligibility determination must be completed for these infants. If an infant has siblings in the home who receive Medicaid under the Partners for Healthy Children or Low Income Families Program, the infant may be added to the case with the siblings. If the infant’s eligibility is determined under the Infants Program, the budget group consists of the infant and parents in the home and may also include the siblings, but only the infant is eligible. Once the infant is determined eligible, Medicaid benefits continue for one year regardless of changes in circumstances and the infant continues to meet non-financial criteria.

**Benefits and Services**

As of the date of publication of this Manual, the following Covered Services are provided as Medically Necessary to WellCare’s South Carolina Medicaid Members. This is not a complete list of Covered Services. For questions about Covered Services, call the Provider Services number located on the *Quick Reference Guide*.

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<th>Covered Services and Any Limits</th>
<th>Co-Pays</th>
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<td>Abortions and related services</td>
<td>$0</td>
</tr>
<tr>
<td>• Covered only in the case of rape or incest or if the Member’s life is in danger</td>
<td></td>
</tr>
<tr>
<td>Allergy testing and treatment</td>
<td>$0</td>
</tr>
<tr>
<td>Ambulance transportation</td>
<td>$0</td>
</tr>
<tr>
<td>Ambulatory Surgical Center (ASC)/Short Procedure Unit (SPU) services</td>
<td>$0</td>
</tr>
<tr>
<td>Behavioral health inpatient services</td>
<td>$25 per admission</td>
</tr>
<tr>
<td>Behavioral health outpatient facility services</td>
<td>$0</td>
</tr>
<tr>
<td>Certified Registered Nurse Practitioner services</td>
<td>$0</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>$0</td>
</tr>
<tr>
<td>• Limited to Manual manipulation of the spine to treat vertebrae misalignment</td>
<td></td>
</tr>
<tr>
<td>• Limited to 1 treatment/visit a day, up to 6 treatments/visits each year</td>
<td></td>
</tr>
<tr>
<td>Communicable disease (HIV/AIDS, STDs, syphilis, TB) services</td>
<td>$0</td>
</tr>
<tr>
<td>• Directly observed therapy for TB</td>
<td></td>
</tr>
<tr>
<td>• Education and counseling</td>
<td></td>
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<tr>
<td>• Testing</td>
<td></td>
</tr>
<tr>
<td>• Treatment</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment (DME) and supplies</td>
<td>$0</td>
</tr>
<tr>
<td>Covered Services and Any Limits</td>
<td>Co-Pays</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>• Items that are not covered include wheelchair accessories and ramps, gloves, car/individual lifts, etc.</td>
<td></td>
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<tr>
<td>• Repairs not covered under the manufacturer’s warranty are covered</td>
<td></td>
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<tr>
<td>• Replacement is covered if the equipment is still Medically Necessary at the time of replacement</td>
<td></td>
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<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Well-child services</td>
<td>$0</td>
</tr>
<tr>
<td>• Physicals for sports are not covered</td>
<td></td>
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<tr>
<td>Emergency medical services</td>
<td>$0</td>
</tr>
<tr>
<td>Eye exams for Members under age 21, and 1 set of glasses per year</td>
<td>$0</td>
</tr>
<tr>
<td>Family planning services These services are available by Fee-For-Service (FFS) or by your Managed Care Organization. Services must be obtained from any approved Medicaid enrolled Provider:</td>
<td>$0</td>
</tr>
<tr>
<td>• Annual visit</td>
<td></td>
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<tr>
<td>• Contraception and supplies</td>
<td></td>
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<tr>
<td>• Family planning and HIV counseling</td>
<td></td>
</tr>
<tr>
<td>• Lab tests</td>
<td></td>
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<tr>
<td>• Pregnancy testing</td>
<td></td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC) services</td>
<td>$0</td>
</tr>
<tr>
<td>Gastric Bypass Surgery/Vertical-Banded Gastroplasty (Gastric Stapling).</td>
<td></td>
</tr>
<tr>
<td>Covered if the surgery meets both of the following criteria:</td>
<td></td>
</tr>
<tr>
<td>• It is medically appropriate and necessary.</td>
<td></td>
</tr>
<tr>
<td>• It is to correct an illness that caused the obesity or was aggravated by the obesity.</td>
<td></td>
</tr>
<tr>
<td>Gastric Bypass Surgery/Vertical-Banded Gastroplasty (Gastric Stapling)</td>
<td>Inpatient and/or outpatient co-pays apply</td>
</tr>
</tbody>
</table>
### Covered Services and Any Limits

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Co-Pays</th>
</tr>
</thead>
</table>
| **Panniculectomy**
  Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. The procedure Liposuction and Abdominoplasty can be covered if:
  - It is medically appropriate and necessary for the individual to have such surgery.
  - The surgery is performed to correct an illness caused by or aggravated by the pannus. |         |
| **Hearing services (for Members under age 21)**
  - Newborn hearing screening in hospital setting
  - Cochlear implants
  - Ear molds – 4 for each ear, every year
  - Hearing aids – fittings, related hearing services, testing | $0      |
| **Home health services**
  - Home health aide visits
  - Skilled nursing visits
  - Therapy visits – occupational, physical and speech therapies
  - Up to 50 visits each year
  - Services that are not covered include full-time nursing, drugs, home-delivered meals, homemaker services, routine supplies and home health services provided in a nursing home and/or institution | $0      |
| **Hysterectomy services (when Medically Necessary)**
  - Advance written and verbal notification to the Member that she will be permanently unable to have children is required; the notification must be signed and dated by the Member
  - Hysterectomies are not covered if done only to prevent pregnancy | $0      |
<table>
<thead>
<tr>
<th>Covered Services and Any Limits</th>
<th>Co-Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital services (physician care and rehabilitation)</td>
<td>$25 per admission</td>
</tr>
<tr>
<td>Institutional long-term care facilities/nursing homes</td>
<td>$0</td>
</tr>
<tr>
<td>- Limited to the first 90 consecutive days</td>
<td></td>
</tr>
<tr>
<td>- Maximum limit of covered days is 120</td>
<td></td>
</tr>
<tr>
<td>Internal prosthetic devices</td>
<td>$0</td>
</tr>
<tr>
<td>Lab and X-ray services and diagnostic tests</td>
<td>$0</td>
</tr>
<tr>
<td>Maternity services</td>
<td>$0</td>
</tr>
<tr>
<td>- Birthing centers for obstetrical and newborn care</td>
<td></td>
</tr>
<tr>
<td>- Prenatal, delivery and postpartum services and nursery charges</td>
<td></td>
</tr>
<tr>
<td>Optometrist services (for Members under age 21)</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient hospital (non-emergency) services</td>
<td>$3.40</td>
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<tr>
<td>Outpatient pediatric AIDS clinic services</td>
<td>$0</td>
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<tr>
<td>Outpatient rehabilitative therapy services</td>
<td>$3.40</td>
</tr>
<tr>
<td>Physician services</td>
<td>$0</td>
</tr>
<tr>
<td>Physical therapy, occupational therapy, speech therapy and audiology</td>
<td>$0</td>
</tr>
<tr>
<td>Pharmacy services</td>
<td>$0</td>
</tr>
<tr>
<td>- $0 (for Members ages 18 and under)</td>
<td></td>
</tr>
<tr>
<td>- $3.40 (for Members ages 19 and above)</td>
<td></td>
</tr>
<tr>
<td>Podiatry services</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive and Rehabilitative Services for Primary Care Enhancement (PSPCE/RSPCE)</td>
<td>$0</td>
</tr>
<tr>
<td>- Evaluation of health status and needs</td>
<td></td>
</tr>
<tr>
<td>- Identification of risk factors</td>
<td></td>
</tr>
<tr>
<td>- Development of care plan</td>
<td></td>
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<tr>
<td>- Education and counseling</td>
<td></td>
</tr>
<tr>
<td>Rural Health Clinic (RHC) services</td>
<td>$0</td>
</tr>
<tr>
<td>Substance abuse treatment services provided by DAODAS (Department of Alcohol and Other Drug Abuse Services) and its subcontracted Providers</td>
<td>$0</td>
</tr>
</tbody>
</table>
Covered Services and Any Limits | Co-Pays
--- | ---
Sterilization services (for Members age 21 and older who are mentally competent, not in an institution and have consented to the service)  
- Advanced informed consent to the Member is required | $0

Transplant services  
- Bone marrow, cornea, heart, kidney, liver, lung, multivisceral, pancreas, small bowel  
- All services provided 72 hours before surgery, post-transplant services following discharge and post-transplant pharmacy services | $0

**Extra Benefits for Members**
WellCare offers extra benefits to Members at no cost and include:

- Diaper Rewards Program  
  New moms and babies are eligible for diaper rewards for completing postpartum and well-child checkups
- Over-the-Counter Items  
  $120 a year ($10 a month) for over-the-counter drugs and supplies, such as diapers, vitamins and almost 100 other items
- Circumcisions  
  Covered for infants up to 6 months of age
- Healthy Rewards Program  
  WellCare of South Carolina will reward Members for participating in the Healthy Rewards Program. Upon completion of qualified healthy behaviors, indicated on the chart below, Members will receive rewards. Participating pregnant Members who complete their prenatal and postpartum visits can choose between a stroller or a convertible car seat.
- Electric Breast Pump  
  New moms can receive an electric breast pump between 3 weeks prior to delivery and up to 30 days after delivery (within 90 days for babies admitted to NICU).
- No Cost Cell phone  
  Members can receive a cellphone at no cost with 350 monthly minutes along with unlimited text messaging.
- XtraSavings Program  
  Members can receive discounts from two programs:  
  - **OTC4Me**: Members can receive discounts on more than 500 everyday over-the-counter items. Save on vitamins, toothpaste, diapers and much more.
Members will enjoy a 20% discount on their first order and then receive a 10% discount on each order after that.

- **CVS Discount Card**: Members will receive a CVS discount card in the mail. It can be used at CVS stores or CVS.com on health and wellness items.

- **Hypoallergenic Bedding**
  WellCare will provide hypoallergenic bedding for qualified members with asthma.

- **4-H Club Membership**
  The cost of annual membership is covered for members 5 to 18 years of age.

- **Sports Activity Fee**
  Members age 5-18 who complete their annual well-child visit and attest to it in the Healthy Rewards program will be eligible to have their sports activity fee covered (registration fee only, up to $40).

- **Steps2Success**
  Members can participate in the following program to improve their employment, financial, and educational goals:
  - **Training** – Members 18 and older can receive job training and financial education classes within their local community.
  - **Reading Scholarships** – Qualified Members who are in pre-kindergarten to fifth grade who want to improve their reading skills may receive a reading scholarship.
  - **GED Program** – Qualified Members age 16 and older may receive a voucher to take their GED test at no cost.

### Healthy Rewards Program Chart

<table>
<thead>
<tr>
<th>Healthy Rewards Program</th>
<th>Focus Area</th>
<th>Activity Criteria</th>
<th>Incentive Type</th>
<th>Incentive Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children’s Health</strong></td>
<td>0-15 Months</td>
<td>Complete well-child health visits per well-child checkup schedule. Members can complete up to 6 visits.</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$10 per visit for a total of $60</td>
</tr>
<tr>
<td></td>
<td>3-6 years</td>
<td>Annual Child health check-up visit</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
</tr>
<tr>
<td></td>
<td>12-17 years</td>
<td>Annual Adolescent check-up visit</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Healthy Pregnancy</strong></td>
<td>Prenatal Care Visits</td>
<td>Members must complete a prenatal visit</td>
<td>Visa Prepaid</td>
<td>$25</td>
</tr>
<tr>
<td>Service Description</td>
<td>Requirement</td>
<td>Reward Type</td>
<td>Reward Value</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td><strong>Completion of Prenatal Visit</strong></td>
<td>Members who complete a prenatal visit have the choice to receive a reward in the Incentive Value column</td>
<td>Bonus Reward</td>
<td>Choice of a stroller, portable playpen, car seat or six packs of diapers.</td>
<td></td>
</tr>
<tr>
<td><strong>Postpartum Care Visit</strong></td>
<td>Attend 1 postpartum visit 21-56 days after the birth of the baby (age 12 and up)</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td><strong>Chronic Care Management</strong></td>
<td>Diabetes</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete an annual eye exam (Members with diabetes ages 18-75)</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete an annual HbA1C lab test (Members with diabetes ages 18-75)</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete a Blood Pressure Control check with your Provider (Members with diabetes ages 18-75)</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td><strong>Well Women</strong></td>
<td>Cervical Cancer Screening</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete of office visit for an annual cervical cancer screening (pap smear) (ages 21-64)</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td><strong>Screening Mammogram</strong></td>
<td>Completion of annual screening mammogram (ages 50-74)</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td><strong>Chlamydia Screen</strong></td>
<td>Completion of annual screening (ages 16-24)</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td><strong>Adult Health</strong></td>
<td>Annual Adult Health Screening</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete annual adult screening (Wellness Visit – Members age 20 and older)</td>
<td>Visa Prepaid Card, or Gift Card</td>
<td>$25</td>
<td></td>
</tr>
</tbody>
</table>

Non-Covered Services, include, without limitation:
- Gastric Bypass Surgery/Vertical-Banded Gastroplasty (Gastric Stapling)
- Supplemental fasting
- Intestinal bypass surgery
- Gastric balloon for treatment of obesity
- Cosmetic procedures
- Experimental and investigational procedures
- Hypnotherapy

Checkups noted above as annual will result in only one payment per year for the Member.

**Provider Services**

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

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

Provider Relations representatives are available to assist with many Provider requests. Contact the local market office for assistance. To contact a Provider Relations representative, call the Provider Services number located on the South Carolina Quick Reference Guide.

Providers may contact the appropriate departments at WellCare by referring to the Quick Reference Guide on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid](http://www.wellcare.com/South-Carolina/providers/Medicaid).

**Website Resources**

WellCare’s website, [www.wellcare.com/south-carolina](http://www.wellcare.com/south-carolina), offers a variety of tools to assist Providers and their staff.

Available Web resources include:
- Provider Manual
- Quick Reference Guide
- Clinical Practice Guidelines
- Clinical Coverage Guidelines
- Forms and documents
- Pharmacy and Provider lookup (directories)
- Authorization lookup tool
- Training materials and guides/job aids
- Newsletters
- Member rights and responsibilities
- Privacy statement and notice of privacy practices

Secure Provider Portal: Key Features and Benefits of Registering
WellCare’s secure online Provider portal offers immediate access to what Providers need most. All participating Providers who create an account will be assigned permissions by a portal administrator and can use the following features:

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

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

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

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

Self-Service Features
• Ability to receive Member co-pay 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 our new IVR
Providers should have the following information available with each call:

• WellCare Provider ID number
• NPI or Tax ID for validation, if Providers do not have their WellCare ID
• For claims inquiries – provide the Member ID number, date of birth, date of service and dollar amount
• For authorization and eligibility inquiries – provide the Member ID number and date of birth

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

The Phone Access Guide is posted on www.wellcare.com/South-Carolina/providers/Medicaid under the Providers section, “Overview & Resources.”

Additional Resources
The Provider Resource Guide contains information about our secure online Provider Portal, Member eligibility, authorizations, filing paper and electronic claims, appeals, and more. The Resource Guide is on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

Another valuable resource is the Quick Reference Guide, which contains important addresses, phone/tax numbers and authorization requirements. The Quick Reference Guide is on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

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

Participating WellCare Medicaid Providers must, in accordance with generally accepted professional standards, do the following:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973;
- Agree to cooperate with WellCare in its efforts to monitor compliance with its Medicaid contract(s) and/or SCDHHS rules and regulations, and assist WellCare in complying with corrective action plans necessary for us to comply with such rules and regulations;
- Retain all agreements, books, documents, papers, and health 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 healthcare [42 C.F.R. § 422.504(a)(3)(iii).];
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Practice Registered Nurses (APRN) should provide direct Member care within the scope of practice established by the rules and regulations of South Carolina and WellCare guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and APRNs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician extender titles (examples: M.D., D.O., APRN, PA) to Members and to other healthcare professionals;
- Honor at all times any Member’s request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any Member in need of healthcare services;
- Maintain the confidentiality of Member information and records;
- Allow WellCare to use Provider performance data for quality improvement activities;
- Respond promptly to WellCare’s request(s) for health records in order to comply with regulatory requirements;
- Ensure that:
All employed physicians and other healthcare practitioners and Providers comply with the terms and conditions of the Provider Agreement between the Provider and WellCare;

To the extent the physician maintains written agreements with employed physicians and other healthcare practitioners and Providers, such agreements contain similar provisions to the Provider Agreement; and

The physician maintains written agreements with all contracted physicians or other healthcare practitioners and Providers, which agreements contain similar provisions to the Provider Agreement;

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the Member, or the requesting party at no charge, unless otherwise agreed;
- Preserve Members’ dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen;
- Not discriminate in any manner between WellCare Medicaid Members and non-WellCare Medicaid Members;
- Ensure that the hours of operation offered to WellCare Members are no less than those offered to commercial members;
- Not deny, limit or condition the furnishing of treatment to any WellCare Medicaid Members 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 healthcare
  - Medical history
  - Genetic information
  - Evidence of insurability, including conditions arising out of acts of domestic violence
  - Disability
- Freely communicate with and advise Members regarding the diagnosis of the Member’s condition and advocate on the Member’s behalf for the Member’s health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
- Identify Members who need services related to children’s health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs; and
- 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 Members accessed the services.
Provider Identifiers
All participating Providers are required to have a unique South Carolina Medicaid Provider number and a National Provider Identifier (NPI). For more information on NPI requirements, refer to Section 5: Claims. A current Medicaid Provider number is an important Medicaid program integrity control. WellCare verifies current South Carolina Medicaid Provider status by reference to data provided to it periodically by the SCDHHS. It is a Provider’s responsibility to maintain a current South Carolina Medicaid Provider number with the SCDHHS. WellCare may deny reimbursement for claims for Covered Services if it determines that the Provider does not have a current South Carolina Medicaid Provider number at the time it adjudicates the claim.

Advance Directives
Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Living will and advance directive rights may differ between states.

Each WellCare Member (age 18 years or older and of sound mind), should receive information regarding living wills and 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 living wills and advance directives should be made available in Provider offices. Providers are also required to discuss living wills and advance directives with Members during their first primary care visit. Completed forms should be documented and filed in the Member’s medical record.

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

Provider Billing and Address Changes
Prior notice to your Provider Relations representative or Provider Services is required for any of the following changes:

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

Provider Termination
In addition to the Provider termination information included in the Provider Agreement, Providers must adhere to the following terms:
• Providers are required to notify WellCare in writing prior to terminating their network participation with WellCare. WellCare generally requires 90 days’ prior written notice of such termination. However, the terms of your Provider Agreement governs your notification obligations for terminations and you must comply with the time frames set forth in your Provider Agreement, including the method for delivering such notice to WellCare. Adequate notice ensures WellCare Members are timely notified of the termination.
• The effective date of termination is the last day of the month, unless WellCare identifies another date.
• Members in active treatment may continue Medically Necessary care for up to 90 days after the Provider termination, unless the Member completes the treatment or selects another treating Provider before then.

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 South Carolina 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 Provider.

Provider Rights
Each Provider who furnishes services to Medicaid Members shall be assured of the following rights:

• A healthcare professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a WellCare Member regarding the following:
  - The Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
  - Any information the Member needs in order to decide among all relevant treatment options;
  - The risks, benefits and consequences of treatment or non-treatment; or
  - The Member’s right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions;
• To receive information on the grievance, appeal and Fair Hearing procedures, including an Expedited Fair Hearing;
• To have access to WellCare’s policies and procedures covering the authorization of services;
• To be notified of any decision by WellCare to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested;
• To challenge, on behalf of Members, the denial of coverage of, or payment for, medical assistance;
• WellCare’s Provider selection policies and procedures must not discriminate against particular Providers who serve high-risk populations or specialize in conditions that require costly treatment; and
• To be free from discrimination for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

Excluded or Prohibited Services
Providers must verify patient eligibility and enrollment prior to providing services to Members. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, such as non-emergency transportation, are administered outside of the managed care program.

Excluded services are defined as those services that Members may obtain under the South Carolina Medicaid plan, and for which WellCare is not financially responsible. These services may be paid for by the SCDHHS on a fee-for-service or other basis. Providers are required to determine eligibility and Covered Services prior to rendering services. In the event the service(s) is excluded, Providers must submit reimbursement for services directly to the SCDHHS. In the event the service(s) is prohibited, neither WellCare nor the SCDHHS is financially responsible. For more information on prohibited services, refer to the SCDHHS’s website at www.scdhhs.gov/provider.

Members with Special Healthcare Needs
Members with special healthcare needs include Members with the following conditions:

• Intellectual Disabilities or related conditions;
• Serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia or degenerative neurological disorders;
• Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes;
• Children and adults with certain environmental risk factors such as homelessness or family problems that may lead to the need for placement in foster care; and
• Related populations eligible for Supplemental Security Income (SSI)
• Persons who are elderly or disabled
• Persons who are dependent upon mechanical ventilation
• Persons with pervasive development disorders
• Persons enrolled in Medically Complex Children’s waiver
• Persons who are head or spinal cord injured.
The following is a summary of responsibilities specific to Providers who render services to WellCare Members who have been identified with special healthcare needs:

- Refer Members to WellCare’s Care Management program;
- Assess Members and develop plans of care for those Members determined to need courses of treatment or regular care;
- Coordinate treatment plans with Members, family and/or specialists caring for Members;
- Develop 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 Member's 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 healthcare services furnished;
- Coordinate services with other third-party organizations to prevent duplication of services and share the results on identification and assessment of the Member’s needs; and
- Ensure the Member's privacy is protected as appropriate during the coordination process.

Access Standards

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

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

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Visits</td>
<td>Within 48 hours of Member’s request</td>
</tr>
<tr>
<td>PCP – Routine/Wellness Visits</td>
<td>Within 4 to 6 weeks of Member’s request</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>Within 4 weeks of Member’s request</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Right away (both in and out of our service area), 24 hours a day, 7 days a week (prior authorization is not required for emergency services)</td>
</tr>
</tbody>
</table>
In-office waiting times for scheduled primary care visits, specialty and urgent care, optometry services, and lab and X-ray services shall not exceed 45 minutes.

Walk-in Members with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Providers may not use discriminatory practices regarding Medicaid Members, such as separate waiting rooms, separate appointment days or preference to private pay Members.

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 Members to someone who can render a clinical decision or reach the PCP;
- An answering system with the option to page the physician for a return call within a maximum of 30 minutes; or
- An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes;

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

**Responsibilities of Primary Care Providers**

The following is a summary of responsibilities specific to PCPs who render services to WellCare Members:

- 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 timely Medically Necessary primary and preventive care services to each Member, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for Members under the age of 21;
- Monitor and follow-up care provided by other medical service Providers for diagnosis and treatment, including services available under Medicaid fee-for-service;
- Provide appropriate referrals for potentially eligible women, infants and children to the Women, Infants and Children (WIC) program for nutritional assistance;
- Coordinate the referral of Members to specialists and to services that may be available through Medicaid fee-for-service;
- Maintain a medical record of all services rendered by the PCP and other referral Providers;
- Assure Members are aware of the availability of public transportation where available;
• Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
• Submit an encounter for each visit where the Provider sees the Member or the Member receives any service, including HEDIS® services;
• Ensure Members use Providers in network with Health Plan. If unable to locate a participating WellCare Provider for services required, contact Health Services for assistance. Refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid; and
• Comply with and participate in corrective action and performance improvement plan(s).

Responsibilities of Specialty Providers
Specialty Providers must be board certified or admissible. Additionally, specialty Providers must:
  • Provide consultation summaries or appropriate periodic progress notes to the Member’s PCP on a timely basis, following a referral or routinely scheduled consultative visit; and
  • Notify the Member’s PCP when scheduling a hospital admission or any other procedure requiring the PCP’s approval.

Early and Periodic Screening, Diagnosis and Treatment
Any Provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide EPSDT screening services are responsible for:
  • Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment for all eligible Members, as stated in the periodicity schedule provided by the American Academy of Pediatrics (AAP);
  • Referring the Member to an out-of-network Provider for treatment if the service is not available within WellCare’s network;
  • Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines;
  • Providing vaccinations in conjunction with EPSDT/well-child-visits. Providers are required to use vaccines available without charge under the Vaccines for Children (VFC) program for Medicaid children 18 years old and younger;
  • Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits;
  • Monitoring, tracking and following up with Members:
    o Who have not had a health assessment screening; and
    o Who miss appointments to assist them in obtaining an appointment;
  • Ensuring Members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring
and following up with Members to ensure they receive the necessary medical services.

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

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

For more information on the periodicity schedule based on the AAP guidelines, refer to their website at www.aap.org.

**Resources for Primary Care Offices**

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

- Support of the Provider Relations, Provider Services, Clinical Services and Marketing and Sales departments;
- The tools and resources available on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid; and
- Information about WellCare network Providers for the purposes of referral management and discharge planning.

**Closing of Provider Panel**

Provider shall accept Members as patients as long as the Provider is accepting new patients. When a Provider requests 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 Provider Agreement) prior to the effective date of closing the panel;
- Maintain the panel to all WellCare Members who were provided services before the closing of the panel; and
- Submit written notice of the re-opening of the panel, including a specific effective date.

**Covering 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 Provider in network with WellCare to deliver services on their behalf, unless there is an emergency.
Covering Providers should be credentialed by WellCare, and are required to sign an agreement accepting the negotiated rate and agreeing not to balance bill WellCare Members. For additional information, please refer to Section 6: Credentialing.

In non-emergency cases, if a covering Provider is not contracted and credentialed with WellCare, contact WellCare for approval. For contact information, refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

**Termination of a Member**

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

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

The Provider should complete a PCP Request for Transfer of Member form, attach supporting documentation and fax the form to WellCare’s Provider Services. A copy of the form is available on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid/Forms.

**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 on WellCare’s website at www.wellcare.com/South-Carolina/providers/Clinical-Guidelines.

**Tobacco Cessation**

All FDA-approved tobacco cessation medications are available without Member cost share or Prior Authorization on the preferred drug list (PDL). A list of the available medications is listed on the online PDL at www.wellcare.com/en/South-Carolina/Providers/Medicaid. The FDA approved dosage limits are in place but there are no limits as to age, or number of quit attempts more restrictive than the FDA labeling.

**Adult Health Screening**

An adult health screening should be performed 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.
Hospital/Facility Responsibilities

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

In compliance with Section 1902 (a) (57) of the Social Security Act, hospitals must:

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

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

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

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

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

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

Level of care determinations will be based on nationally recognized criteria (e.g. Interqual, Milliman Clinical Guidelines [MCG]) and Medical Director review.

**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 our Providers fully recognize and care for the culturally diverse needs of the Members they serve.

The objectives of the Cultural Competency program are to:

- Identify Members who have potential cultural or linguistic barriers for which alternative communication methods are needed;
- Use culturally sensitive and appropriate educational materials based on the Member’s race, ethnicity, and primary language spoken;
- Make resources available to address the unique language barriers and communication barriers that exist in the population;
- Help Providers care for and recognize the culturally diverse needs of the population;
- Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served; and
- Decrease healthcare disparities in the minority populations we serve.

Culturally and Linguistically Appropriate Services (CLAS) are healthcare services provided that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent healthcare services requires that healthcare Providers and/or their staff possess a set of attitudes, skills, behaviors, and policies that enable the organization and staff to work effectively in cross-cultural situations. Cultural and linguistic ability must include information on the non-English languages spoken by current WellCare Providers and whether or not the Provider has completed cultural competency training.

The components of WellCare’s Cultural Competency program include:

- Data Analysis – WellCare analyzes data on the populations in each region we serve, learning about that region’s cultural and linguistic needs, as well as any health disparities specific to that region. Such analyses are performed at the time we enter a new market and regularly thereafter, depending on the frequency with which new data become available. Data sources and analysis methods include the following:
  - State-supplied data for Medicaid and CHIP populations;
- Demographic data available from the U.S. Census and any special studies done locally;
- Claims and encounter data to identify the healthcare needs of the population by identifying the diagnostic categories that are the most prevalent;
- Member requests for assistance, or Member grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle;
- Data on race, ethnicity and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers.

- Community-Based Support: Our success requires linking with other groups that share the same goals.
  - WellCare reaches out to community-based organizations that support racial and ethnic minorities, and the disabled, to ensure that existing community resources for Members who have special needs are used to their full potential. The goal is to coordinate the deployment of both community and health plan resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.
  - WellCare develops and maintains grassroots sponsorships that enhance our effort to reach low-income communities. We also provide opportunities for building meaningful relationships that benefit all Members of the communities. These sponsorships are coordinated with Providers, community health fairs and public events.

- Diversity and Language Abilities of WellCare: WellCare recruits diverse talented staff to work in all levels of the organization. We do not discriminate with regard to age, race, color, religion, sex, sexual orientation, gender identity or disability when hiring staff.
  - 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 our Member Services representatives are bilingual. Spanish is the most common translation required. Whenever possible, we will also distinguish place of origin of our Spanish-speaking staff, to ensure sensitivity to differences in cultural backgrounds, language idioms and accents. For example, in Georgia, approximately two-thirds of the Hispanic population is of Mexican origin. In Florida and New York City, the Puerto Rican population is predominant.
  - Where we enroll significant numbers of Members who speak languages other than English or Spanish, WellCare seeks to recruit staff members who are bilingual in English plus one of those other languages. We do this even if the particular population is not of a size that triggers state agency mandates.

- Diversity of Provider Network
- Providers are inventoried for their language abilities. This information is made available in the Provider Directory so that Members can choose a Provider that speaks their primary language.
- Providers are recruited to ensure a diverse selection of Providers to care for the population served.

- Linguistic Services
  - Providers will identify Members who have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance.
  - Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service Department.
  - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency, and sign language for the hearing impaired. These services are provided by vendors with such expertise and coordinated by WellCare’s Customer Service Department. Written materials are available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the potential Member’s or Member’s special needs with disabilities or limited English reading proficiency.
  - WellCare written materials are available for Members in large–print format, and certain non-English languages prevalent in WellCare’s service areas.

- Electronic Media
  - Telephone system adaptations – Members have access to the TTY/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 ID card.

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

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

**Cultural Competency Survey**
Providers may access the Cultural Competency Survey on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid](http://www.wellcare.com/South-Carolina/providers/Medicaid).

**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**

All newly enrolled Members will be sent a Quick Start Guide within five business days of receiving a notice of enrollment from WellCare.

Members can view the Member Handbook (MHB) electronically or download a copy on our website at www.wellcare.com/South-Carolina. In addition, Members may receive a paper copy of the MHB at no charge by contacting WellCare.

**Enrollment**

WellCare must obey laws that protect from discrimination or unfair treatment. WellCare does not discriminate based on a person’s age, race, color, nationality, religion, sex, sexual orientation, gender identity, or disability.

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; and
- Brochures describing certain benefits not traditionally covered by Medicaid and other value-added items or services, if applicable.

**Member Identification Cards**

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

**Eligibility Verification**

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

Providers may do one of the following to verify eligibility:

- Access the WellCare Provider Portal at southcarolina.wellcare.com/login/provider. Providers must be registered and logged in;
- Access WellCare’s Interactive Voice Response (IVR) system. The Provider ID number is needed to access Member eligibility;
- Access www.scdhhs.gov and/or
• Contact the Provider Services Department.

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

**Member Rights and Responsibilities**

WellCare Members, both adults and children, have specific rights and responsibilities in accordance with 42 CFR 438.100 and outlined in the *Member Handbook*. WellCare Members have the right:

- To receive information on WellCare’s services, to include, but not limited to:
  - Benefits covered;
  - Procedures for obtaining benefits, including any authorization requirements;
  - Any cost sharing requirements;
  - Service area;
  - Names, locations, telephone numbers of and non-English language spoken by current contracted Providers, including at a minimum, primary care Providers, specialists and hospitals;
  - Any restrictions on the Member’s freedom of choice among network Providers;
  - Providers not accepting new patients; and
  - Benefits not offered by WellCare but available to Members and how to obtain those benefits, including how transportation is provided;

- To get information about WellCare, its services, its practitioners and Providers and about their Member rights and responsibilities;

- To receive a complete description of disenrollment rights at least annually;

- To receive notice of any significant changes in the benefits package at least 30 days before the intended effective date of the change;

- To receive information on grievance, appeal and fair hearing procedures;

- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post-stabilization services;
  - That emergency services do not require prior authorization;
  - The process and procedures for obtaining emergency services;
  - The locations of any emergency settings, and other locations where Providers and hospitals furnish emergency services, and post-stabilization services covered under the contract;
  - Member’s right to use any hospital or other setting for emergency care; and
  - Post-stabilization care services rules as detailed in 42 CFR §422.113(c);

- To receive WellCare’s policy on referrals for specialty care and other benefits not provided by the Member’s PCP;
• To know the names and titles of doctors and other health Providers delivering care;
• To be treated with respect and with due consideration for his or her dignity and privacy;
• To participate in decisions regarding his or her healthcare, including the right to accept or refuse medical, surgical, or behavioral health treatment;
• To receive healthcare services that are accessible, comparable in amount, duration and scope to those provided under Medicaid fee-for-service, and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished;
• To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition;
• To receive all information, including but not limited to enrollment notices, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood;
• To receive assistance from both SCDHHS and WellCare in understanding the requirements and benefits of WellCare’s plan;
• To receive oral interpretation services at no cost for all non-English languages, not just those identified as prevalent;
• To be notified that oral interpretation is available and how to access those services;
• To talk openly about the care they need, no matter the cost or benefit coverage, and the treatment choices and risks involved. The information must be given in a way they understand;
• To have the risks, benefits and side effects of medications and other treatments explained to them;
• To know about their healthcare needs after they are discharged from the hospital or leave the doctor’s office;
• To refuse to take part in any medical research;
• To file an appeal or grievance about WellCare or the care it provides, and to know if they do file a grievance it will not change how they are treated;
• To not be responsible for WellCare’s debts in the event of bankruptcy and not be held liable for:
  o Covered Services provided to the Member for which the government does not pay the contractor;
  o Covered Services provided to the Member for which the government or WellCare does not pay the Provider who furnished the services; and
  o Payments of Covered Services provided under a contract, by referral or other arrangement, if the amount is in excess of what the Member would owe if WellCare provided the services directly;
• To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restraints and seclusion;
• To be able to request and receive a copy of their health records, and request that they be amended or corrected;
• To have their records kept private; nationality
• To have their privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A, C and E, to the extent that they are applicable;
• To make their healthcare wishes known through advance directives;
• To have a say in WellCare’s Member rights and responsibilities policy;
• To appeal medical or administrative decisions by using WellCare’s appeal and grievance process;
• To exercise these rights no matter their age, color, nationality, sex, sexual orientation, gender identity, disability, or religion;
• To exercise these rights without adversely affecting the way WellCare, its Providers or SCDHHS treat them;
• To have all WellCare staff observe their rights;
• To have all the above rights apply to the person legally able to make decisions about their healthcare;
• To be furnished quality services in accordance with 42 CFR 438.206 through 438.210, which include:
  o Accessibility
  o Authorization standards
  o Availability
  o Coverage
  o Coverage outside of network
  o The right to a second opinion
• To be responsible for cost sharing only as specified in the contract; and
• As a potential Member, to receive information about the basic features of managed care; which populations may or may not enroll in the program; and WellCare’s responsibilities for coordination of care in a timely manner, in order to make an informed choice.
• Decide with their doctor on the care they get.

Members have the responsibility:

• To read the Member Handbook to understand how WellCare works;
• To carry their Member ID card at all times;
• To give information that WellCare and its doctors and Providers need to provide care;
• To follow plans and instructions for care that they have agreed on with their doctor;
• To understand their health problems;
• To help set treatment goals agreed upon by the Provider and the Member;
• To carry their Medicaid card at all times;
• To show their Member ID card to each Provider;
• To schedule appointments for all non-emergency care through their doctor;
• To get a referral from their doctor for specialty care;
• To cooperate with the people who provide their healthcare;
• To be on time for appointments;
• To tell the doctor’s office if they need to cancel or change an appointment;
• To pay their co-payments to Providers, as specified by the South Carolina Healthy Connections program;
• To respect the rights of all Providers;
• To respect the property of all Providers;
• To respect the rights of other patients;
• To not be disruptive in the doctor’s office;
• To know the medicines they take, what they are for and how to take them the right way;
• To make sure their doctor has copies of all previous health records;
• To let WellCare know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care; and
• To be responsible for cost sharing only as specified under Covered Services and co-payments.

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

If a Provider’s name is not identified as the PCP on the Member’s card, the Member may see that Provider, as long as the Provider is participating in network.

Changing Primary Care Providers
Members may change their PCP selection at any time by calling Customer Service. Providers can also assist Members when changing their designated PCP, by completing the PCP Change Request Form, while the Member is in the Provider’s office. The form is at www.wellcare.com/South-Carolina/providers/Medicaid/Forms.

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

Hearing-Impaired, Interpreter and Sign Language Services
Hearing-impaired, interpreter and sign language services are available to WellCare Members through WellCare’s Customer Service. PCPs should coordinate these services for WellCare Members and contact Provider Services if assistance is needed. Please refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid for Provider Services telephone numbers.
Section 3: Quality Improvement

Overview
WellCare's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral healthcare and services. Strategies are identified and activities implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas including:

- Quantitative and qualitative improvement in Member outcomes
- Confidentiality
- Coordination and continuity of care with seamless transitions across healthcare settings/services
- Cultural competency
- Quality of care/services
- Credentialing
- Preventive health
- Grievances
- Network adequacy
- Appropriate service utilization
- Disease and care management
- Behavioral health services
- Appeals and grievances
- Member and Provider satisfaction
- Components of operational service
- Regulatory/federal/state/accreditation requirements

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

The goals of the QI Program are to:

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

Provider Participation in the Quality Improvement Program
Network Providers are contractually required to comply with WellCare’s quality improvement program, which includes providing Member records for assessing quality of care. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule of 45 CFR 164.506 and rules and regulations promulgated thereunder (45 CFR Parts 160, 162, and 164) permits a covered entity (Provider) to use and disclose protected health information (PHI) to health plans without Member authorization for treatment, payment and healthcare operations activities. Healthcare operations include, but are not limited to the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination. Providers must also allow WellCare to use Provider performance data.

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

Information regarding the QI Program is available upon request and includes a description of the QI Program and a report assessing the progress in meeting goals. WellCare evaluates the effectiveness of the QI Program on an annual basis. An annual report is published which reviews completed and continuing QI activities and 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. This report is available as a written document.

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

Early and Periodic Screening, Diagnosis and Treatment Periodicity Schedule
The EPSDT Program provides comprehensive and preventive health services to children through the month of their 21st birthday according to the American Academy of Pediatric...
AAP) periodicity schedule. The periodicity schedule is available on the AAP website. The preventive pediatric healthcare guidelines for children are located at www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CPGs. The PCP is responsible for assuring the availability and accessibility of required healthcare services in their office for Members paneled to the PCP and for helping the Member and their parents or guardians effectively use these resources.

A Member should have an initial health check screening in the following situations:

- Within 90 days of joining WellCare or upon change to a new PCP, if prior health records do not indicate current compliance with the periodicity schedule; and
- Within 24 hours of birth for newborns.

A child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening should be performed at age 5.

The medical record must contain documentation of a comprehensive health and developmental history during the initial visit, in addition to a complete comprehensive 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

Additional points of emphasis regarding EPSDT screens include the following:

- **Visit Requirements** – An interval comprehensive health history, age-appropriate assessment of physical and behavioral health development, assessment of nutrition, complete unclothed physical exam, age-appropriate health education/anticipatory guidance and growth chart are completed at each visit.
- **Immunizations** are administered at required age parameters and intervals with dates documented. If the immunizations are not up to date according to age and health history, the Provider should document why immunizations were not given
at the time of the EPSDT screen. For the immunization schedule, refer to the preventive pediatric healthcare guidelines for children located at www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CPGs. Note that certain immunizations may not be covered in the context of covered benefits.

• **PCP Responsibilities** – A PCP is responsible for performing all required components of an EPSDT health screen, as per the AAP and ACIP periodicity schedules, and documenting appropriately in the Member’s medical record. If a PCP chooses not to provide the immunization component of the screen, she or he has accountability to refer the Member to another network Provider (such as a health department entity) who can provide this service in a timely manner. WellCare 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 with these requirements by reviewing immunization rates of the PCP. In the event the immunization rate of a PCP is less than the network average, WellCare will:
  o Conduct an audit to verify compliance with access and availability;
  o Require adoption of a corrective action plan if access and availability standards are not met; and
  o Perform a focused medical record review. Based on negative findings, a corrective action plan will be requested.
    ▪ If compliance with the corrective action plan is not demonstrated, WellCare will assess for a fee reduction; and
    ▪ If lack of compliance continues, WellCare will remove the PCP from network participation.

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

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

• **Laboratory tests** are required at specific ages as outlined by the American Academy of Pediatrics (AAP) periodicity schedule, which should be provided.

• **Health Education** must be provided based on the Member’s age and development history. In addition, Members should be provided anticipatory guidance according to AAP Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.

• **Vision Services** – Vision testing should be conducted in accordance with the AAP periodicity schedule. Referrals should be made as necessary to appropriate vision Providers.

• **Dental Services** – The PCP must refer Members for appropriate dental services according to the AAP periodicity schedule.
- **Hearing Services** – The PCP must perform hearing screening and referral services according to the AAP periodicity schedule, as necessary.
- **Developmental Delay** is to be assessed by use of a formalized tool at 9 and 18 months, and at 2 and 3 years.
- **120 day Non-Compliant Report** is provided by WellCare and 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 must 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.

**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 Provider may supersede *Clinical Practice Guidelines*, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations. The *Clinical Practice Guidelines* are based on peer-reviewed medical evidence and are relevant to the population served. Providers are also measured annually for their compliance with *Clinical Practice Guidelines*. Areas identified for improvement are tracked and corrective actions are taken as indicated. The effectiveness of corrective actions is monitored until the problem is resolved. Approval of the *Clinical Practice Guidelines* occurs through the Quality Improvement Committee. *Clinical Practice Guidelines*, including preventive health guidelines, are on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CPGs](http://www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CPGs).

**Healthcare Effectiveness Data and Information Set (HEDIS®)**

HEDIS® is a tool used by more than 90% of America’s health plans to measure performance on important dimensions of care and service. The tool comprises 92 measures across six domains of care, including:

- Effectiveness of Care
- Access and Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information and

HEDIS® is a mandatory process that occurs annually. It is an opportunity for WellCare and Providers to demonstrate the quality and consistency of care that is available to Members. Health records and claims data are reviewed for capture of required data. Compliance with HEDIS® standards is reported on an annual basis with results available to Providers upon request. Through compliance with HEDIS® standards, Members benefit from the quality and effectiveness of care received, and Providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.
Health Records
Providers shall maintain a comprehensive health record that reflects all aspects of care for each Member. Providers shall maintain medical records in a secure, timely, legible, current, detailed, accurate and organized manner in order to permit effective and confidential patient care and quality review. Records should be safeguarded against loss, destruction or unauthorized use, be maintained in an organized fashion for all individuals evaluated or treated, and must be accessible for review and audit. Providers must maintain individual health records for each Medicaid Member. Such records shall be readily available to the SCDHHS and/or its designee and contain all information necessary for the medical management of each enrolled Medicaid Member. Procedures should also exist to facilitate the prompt transfer of patient care records to other in- or out-of-plan Providers. A comprehensive health record includes, but is not limited to:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other healthcare professionals findings
- Appointment records
- Other documentation sufficient to show evidence of care and screenings and to disclose the quantity, quality appropriateness, and timeliness of service provided

Health records must be signed and dated by the Provider of service.

The Member’s health record is the property of the Provider who generates the record. However, each Member or designated representative is entitled to one copy of her or his health record at no charge. Additional copies shall be made available to Members at cost.

WellCare follows state and federal law regarding the retention of records remaining under the care, custody and control of the Provider. Each Provider must retain health records in their original or legally reproduced form for a period of at least 10 years.

Each Provider is required to maintain a primary medical record for each Member, which contains sufficient medical information from all Providers involved in the Member’s care to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:

- Member identification information on each page;
- Personal/biographical data, including:
  - Member name
  - Medicaid identification number
  - Date of birth
  - Age
  - Gender
  - Marital status
- Race or ethnicity
- Mailing address
- Home and work addresses and telephone numbers
- Employer
- School
- Emergency contact name and telephone numbers (if no phone contact name and number)
- Consent forms
- Identification of language spoken
- Responsible party and/or guardianship information

- Services provided, date of service, service site, and name of service Provider;
- Date of data entry and date of encounter;
- Allergies and adverse reactions shall be noted in a prominent location;
- Past medical history, including serious accidents, operations, illnesses, diagnoses, prescribed treatment and/or therapy, and drugs administered or dispensed. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (e.g., documentation of chicken pox);
- Referrals and results of specialist referrals;
- Identification of current problems;
- Consultation, laboratory, and radiology reports shall be filed in the medical record and must have documentation indicating review (ordering Provider’s initials);
- Signed and dated consent forms;
- Documentation of immunizations;
- Identification and history of nicotine, alcohol use or substance abuse;
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides;
- Documentation of emergency room care and/or after-hours encounters and follow-up visits provided;
- Hospital discharge summaries;
- Documentation of advanced directives for adults;
- For pediatric records (under 19 years of age) record of immunization status and documentation of advance directives, if completed;
- All written denials of service and the reason for the denial; and
- Record should be legible to a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

A Member’s medical record shall include the following minimal detail for individual visits/clinical encounters:

- Date
- Purpose of visit
- Diagnosis or medical impression
- Objective findings
- Assessment of patient’s findings
• Plan of treatment including:
  o Diagnostic tests, therapies and other prescribed regimens
  o Medications history and medications prescribed, including strength, amount, directions for use and refills
  o Health education provided
  o Follow-up plans including consultation and referrals and directions, including time to return

• Signature and title or initials of the Provider rendering the services. If more than one person documents in the medical record, there must be a record on file to identify the signature and representative initials

• History and physical examination for presenting grievances containing relevant psychological and social conditions affecting the patient’s medical/behavioral health, including mental health, and substance abuse status

• Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits

PCPs and OB/GYNs acting as PCPs may be reviewed for their compliance with medical record documentation standards. Identified areas for improvement are tracked and corrective actions are taken as indicated. Effectiveness of corrective actions is monitored until problem resolution occurs.

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to WellCare, or its representatives, without a fee to the extent permitted by state and federal law. Providers shall have procedures in place to permit the timely access and submission of health records to WellCare upon request. Information from the health records review may be used in the re-credentialing process as well as quality activities.

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

Patient Safety to Include Quality of Care and Quality of Service
Programs promoting patient safety are a public expectation, a legal and professional standard, and an effective risk-management tool. As an integral component of healthcare 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 healthcare network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues, 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 Member 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 use screening tools and ongoing monitoring and measuring of outcomes. While WellCare can and does implement activities to identify interventions, the support and activities of families, friends, Providers and the community have a significant impact on prevention.

**Web Resources**
WellCare periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare’s website frequently for the latest news and updated documents at [www.wellcare.com/South-Carolina/providers/Medicaid/Quality](http://www.wellcare.com/South-Carolina/providers/Medicaid/Quality).
Section 4: Utilization Management, Care Management and Disease Management

Utilization Management

Overview
For purposes of this Utilization Management (UM) section, terms and definitions may be contained within this section, in Section 12: Definitions and Abbreviations, or both.

The focus of the UM Program is on:

- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness, and consistency with the Member’s diagnosis, and level of care required;
- Providing access to medically appropriate, cost-effective healthcare 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 healthcare behaviors and Member partnership;
- Facilitating communication and partnerships among Members, families, Providers, delegated entities and WellCare in an effort to enhance cooperation and appropriate utilization of healthcare services;
- Reviewing, revising and developing medical coverage policies to ensure Members have appropriate access to new and emerging technology; and
- Enhancing coordination and minimizing barriers in the delivery of behavioral and medical healthcare 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 healthcare and services based on WellCare Members’ coverage and the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

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

Medically Necessary Services
The determination of whether a covered benefit or service is Medically Necessary or a Medical Necessity shall:

- Be based on an individualized assessment of the recipient’s medical needs; and
- Comply with the following requirements and be:
o Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;

o Appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice;

o Provided for medical reasons rather than primarily for the convenience of the individual, the individual’s caregiver, or the healthcare Provider, or for cosmetic reasons;

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

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

o Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements for individuals under 21 years of age; and


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

The UM Program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- Milliman Clinical Guidelines (MCG)
- Interqual
- WellCare Clinical Coverage Guidelines
- Medical necessity
- State Medicaid Contract
- State Provider handbooks, as appropriate
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment
- American Society of Addition Medicine (ASAM)

The clinical reviewer and/or medical director involved in the UM process applies Medical Necessity criteria in context with the Member’s individual circumstance and the capacity of the local Provider delivery system. When the above criteria do not address the individual Member’s needs or unique circumstance, the medical director will use clinical judgment in making the determination.
The review criteria and guidelines are available to Providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by calling the Provider Services Department listed on the Quick Reference Guide on WellCare's website at www.wellcare.com/South-Carolina/providers/Medicaid. Providers may advise and comment on the development and adoption of clinical criteria through their Provider representative who can provide contact information for the Chair of the Medical Policy Committee or another WellCare medical director.

**Utilization Management Process**
The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Prior authorizations
- Concurrent review
- Retrospective review

Decision and notification time frames are determined by NCQA® requirements, contractual requirements, or a combination of both.

WellCare forms for the submission of notifications and authorization requests can be found at www.wellcare.com/South-Carolina/providers/Medicaid/Forms.

**After-Hours Utilization Management**
WellCare processes requests and provides information for the routine or urgent authorization of services, utilization management functions, Provider and Member questions or comments 24 hours per day, seven days per week. Providers requesting after-hours authorization for inpatient admission should refer to the Quick Reference Guide at www.wellcare.com/South-Carolina/providers/Medicaid to contact an after-hours nurse. WellCare’s after-hours nurse will handle discharge planning needs that may occur after normal business hours.

**UM Notification**
UM notifications are communications to WellCare with information related to a service rendered to a Member or a Member’s admission to a facility. Such notifications are required for:

- Prenatal services – Notification of pre-natal services enables WellCare to identify pregnant Members for inclusion into the Prenatal Program and/or WellCare’s High Risk Pregnancy Program. Obstetrical Providers are required to notify WellCare of pregnancies via fax using the Prenatal Notification Form within 30 days of the initial visit. This process will also expedite care management and claims reimbursement; and
- Inpatient Admission – Notification of a Member’s admission to a hospital allows WellCare to log the hospital admission and follow up with the facility on the following business day to receive clinical information. The notification should be
Referrals
A referral is a request by a PCP for a Member to be evaluated and/or treated by a specialty Provider. WellCare does not require authorization as a condition of payment for specialist consultations provided by WellCare-contracted Providers. WellCare does not need to be notified when Members are referred to in-network Providers. Please see the Prior Authorization section below if the Member is being referred to an out-of-network Provider. Certain diagnostic tests and procedures considered by WellCare to be routinely part of an office visit may be conducted as part of the initial visit without an authorization. A searchable Authorization Lookup Tool is available online at www.wellcare.com/South-Carolina/providers/Authorization-Lookup.

WellCare does not require Providers to perform any treatment or procedure that is contrary to the Provider’s conscience, religious beliefs, or ethical principles in accordance with 42 CFR 438.102 and S.1932(b)(3)(B) of the Social Security Act. If a Provider declines to perform a service because of ethical reasons, the Members should be referred to another Provider licensed, certified or accredited to provide care for the individual service, or be assigned to another PCP licensed, certified or accredited to provide care appropriate to the Member’s medical condition. WellCare does not prohibit or restrict a Provider from advising a Member about his or her health status, medical care or treatment, regardless of whether benefits for such care are Covered Services, if the Provider is acting within the lawful scope of practice.

Prior Authorization
Prior authorization is the process of obtaining approval in advance of rendering a service. Prior authorization may or may not require a medical record review. Prior authorization is issued for medical necessity and is not a guarantee of payment. Payment is subject to limitations and exclusions of the Member’s benefit plan. Prior authorization allows for efficient use of covered healthcare services and ensures that Members receive the most appropriate level of care, at the most appropriate setting. Prior authorization may be obtained by the Member’s PCP, treating specialist or facility.

Reasons for requiring prior authorization may include:

- Review for medical necessity
- Appropriateness of rendering Provider
- Appropriateness of setting
- Care and disease management considerations

Prior authorization is required for elective or non-emergency services as designated by WellCare. Guidelines for prior authorization requirements by service type may be found on the Quick Reference Guide at www.wellcare.com/South-Carolina/providers/Medicaid. Providers can also use the searchable Authorization Lookup Tool at www.wellcare.com/South-Carolina/providers/Authorization-Lookup.
Some prior authorization guidelines to note are:

- The prior authorization request should include the diagnosis to be treated and the *Physician’s Current Procedural Terminology, 4th Edition* (CPT-4) code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required.
- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency, total number of visits requested and the expected duration of care. The authorization request form should also be accompanied by any pertinent clinical information such as physician notes and diagnostic reports.

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

There is no limit on the number of days Medicaid allows for Medically Necessary inpatient hospital care. If a Member is 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.

**Authorization Request Forms**

In order to obtain authorization to provide a covered service that requires prior authorization, WellCare requests that Providers complete a WellCare *Authorization Request Form* or the *South Carolina Universal Authorization Form* and submit to WellCare. Descriptions of these forms are listed below.

- **Inpatient Authorization Request Form** is used to request authorization for services such as planned elective/non-urgent inpatient, observation, inpatient, skilled nursing facility and rehabilitation admissions.
- **Outpatient Authorization Request Form** is used to request authorization for services such as select outpatient hospital procedures, out-of-network services and transition of care services.
- **DME Ancillary Services Request Form** is used to request authorization for Durable Medical Equipment.
- **Home Health Services Request Form** is used to request authorization for home care services.
- **Skilled Therapy Services Request Form** is used to request physical, occupational and speech therapy services. (Services may be processed by a vendor. Please refer to the *Quick Reference Guide* (QRG) for specific information.)
- **17-P Universal Authorization Form** is used for the ordering and use of 17-P injections to reduce the risk of pre-term birth in women with a singleton pregnancy who have a history of singleton spontaneous pre-term birth.
- **Medications Prior Authorization Form** is the accepted prior authorization form for medications.
- **Universal Newborn Prior Authorization Form** is for services rendered in an office setting within 60 days following hospital discharge.
- South Carolina Department of Mental Health CMHC Treatment Review & Authorization Request is used to request authorization for Rehabilitative Behavioral Health Services (RBHS).

To ensure timely and appropriate claims payment, all forms must:

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

Incomplete 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/South-Carolina/providers/Medicaid/Forms](http://www.wellcare.com/South-Carolina/providers/Medicaid/Forms).

Providers may submit requests for authorization by:

- Submitting an online authorization request via WellCare’s secure Provider web portal at [www.wellcare.com](http://www.wellcare.com); (this option provides faster service)
- Faxing a properly completed form; or
- Contacting WellCare via phone for inpatient notifications and urgent outpatient services.

For questions about the Utilization Management Program, please call Provider Services at 1-866-231-1821. TTY/TDD users call 711. Language services are offered.

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

The attending physician or hospital staff is responsible for obtaining prior authorization from WellCare and for providing the prior authorization number to each WellCare Provider associated with the case (e.g., assistant physician, hospital, etc.). Failure to obtain prior authorization will result in denial of payment.

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

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

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

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

**Procedures for Obtaining Prior Authorization for Transplants**

All potential kidney transplants, cadaver or living donor, must be authorized by the SCDHHS-contracted Quality Improvement Organization (QIO) before the services are performed. The QIO will review all Medicaid referrals for organ transplants and issue an approval or denial. The following potential transplants, cadaver or living donor, must be authorized by the QIO before the services are performed:

- Bone marrow (Autologous Inpatient and Outpatient, Allogeneic Related and Unrelated, Cord, and Mismatched)
- Pancreas
- Heart
- Liver
- Liver with small bowel
- Liver/pancreas
- Kidney/pancreas
- Lung
- Heart/lung
- Multi-visceral
- Small Bowel

The Department will review all Medicaid referrals for organ transplants and issue an approval or denial. For in-state evaluations and transplants the WellCare medical director will make a medical necessity determination and forward any approved requests to KEPRO, fax number 1-855-300-0082 or scdhhs.KEPRO.com/. Unapproved requests for in-state transplant evaluations remain the responsibility of the WellCare.

For out-of-state evaluations and transplants, WellCare’s medical director will make a medical necessity determination and determine if it should be approved. If approved the WellCare medical director shall contact the Department’s medical director to obtain approval of the medically necessity for both the evaluation and the transplant. Upon approval by the Department’s medical director, WellCare shall submit the request along with the written approval issued by the Department’s medical director to KEPRO for issuance of a prior authorization request. This request is an operational requirement to
ensure the transplant claim is paid appropriately by Healthy Connections. Additionally, the WellCare is responsible for all services prior to 72 hours pre-admission, post-transplant services upon discharge, and post-transplant pharmacy services.

All potential Group II transplants, cadaver or living donor, except for matched bone marrow (autologous inpatient and outpatient, allogeneic related and unrelated and cord), must be authorized by the QIO before the services are performed. The Department will review all Medicaid referrals for organ transplants and issue an approval or a denial.

If the transplant is approved, the approval letter serves as authorization for pre-transplant services (72 hours preadmission), the event (hospital admission through discharge), and post-transplant services up to 90 days from the date of discharge. For requests for approval of coverage for transplant services, contact WellCare’s Utilization Management Department at the telephone number listed on the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid/Forms.

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

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

Notification of a Member’s admission to a hospital allows WellCare the ability to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone and include Member demographics, facility name and admitting diagnosis. Notification of an acute inpatient admission is required within one business day.

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

Concurrent review is initiated as soon as WellCare is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity. The continued length-of-stay authorization will occur concurrently based on Milliman Clinical Guidelines (MCG) criteria or other clinical criteria used by WellCare for appropriateness of continued stay to:

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

The concurrent review process incorporates the use of Milliman Clinical Guidelines (MCG) criteria and other medical necessity criteria used by WellCare to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the WellCare medical director.

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

Discharge Planning
Discharge planning begins upon admission and is designed for early identification of medical and/or psycho-social issues that will need post-hospital intervention. The inpatient care 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 care nurse may refer an inpatient Member with identified complex discharge needs to short-term care management for post-discharge follow-up.

Retrospective Review
A retrospective review or Post-Service Medical Necessity 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:
  o WellCare requires periodic documentation including, but not limited to, the medical record, UB, and/or itemized bill to complete an audit of the Provider-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, health records should be submitted to WellCare to support accurate coding and claims submission.

• Post-Service Medical Necessity Review initiated by Providers:
  WellCare will review for medical necessity 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 rational behind failure to follow WellCare’s Prior Authorization/pre-certification guidelines.

WellCare will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If WellCare is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to 14 calendar days of the post-service request.

The Member or Provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Health Services’ Utilization Management Department. Refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

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

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<thead>
<tr>
<th>Type of Authorization</th>
<th>Initial Decision Time Frame</th>
<th>Extension Length</th>
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<tbody>
<tr>
<td>Standard Pre-service</td>
<td>14 calendar days</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Expedited Pre-service</td>
<td>72 hours</td>
<td>14 calendar days</td>
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<tr>
<td>Concurrent</td>
<td>24 hours</td>
<td>48 hours</td>
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<tr>
<td>Post-service</td>
<td>30 calendar days</td>
<td>14 calendar days</td>
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#### Standard Service Authorization

WellCare is committed to processing prior authorization requests within 14 calendar days. WellCare will fax an authorization response to the Provider fax number(s) included on the authorization request form. An extension may be granted for an additional 14 calendar days if the Members or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member’s best interest.

#### Expedited Service Authorization

In the event the Provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the Member’s life or health, WellCare will make an expedited authorization determination and provide notice within 72 hours of the request. 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. **Requests for expedited authorization decisions should be submitted by telephone, not fax or via WellCare’s website.** Please refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid for the appropriate contact information.

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

Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed 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 patient needs further care as an inpatient admission or the patient may improve and be released. Observation is a covered revenue code on an inpatient claim.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient charges beginning from the date of initial observation. Outpatient observation services should not be used for services for which an overnight stay is normally expected. Services such as complex surgery clearly requiring inpatient care may not be billed as outpatient.

WellCare only covers services that are medically appropriate and necessary. Failure to obtain the required authorization may result in denial of reimbursement of all services provided and extends to all professional services, not just the hospital.

Medical appropriateness and necessity including that of the medical setting must be clearly substantiated in the Member’s medical record. If the outpatient observation is not covered, then all services provided in the observation setting are also not covered. Services provided for the convenience of the patient or Provider and that are not reasonable or Medically Necessary for the diagnosis are not covered.

Observation services will not require authorization; however, preplanned procedures will be subject to outpatient authorization requirements.

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

- The action WellCare has taken or intends to take;
- The reasons for the action;
- The Member’s right to appeal;
- The Member’s right to request a state hearing, if applicable;
• Procedures for exercising Member’s rights to appeal or file a grievance;
• Circumstances under which expedited resolution is available and how to request it; and
• The Member’s rights to have benefits continue, pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

Peer-to-Peer Review of Proposed Adverse Determination
In the event of a proposed adverse determination following a medical necessity review, peer-to-peer review is offered to the treating physician via telephone or fax within the specified time frames for expedited and standard authorization requests. The treating physician is provided a toll-free number to the medical director hotline to request a discussion with a WellCare medical director.

Services Requiring No Authorization
WellCare has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of Members including:

• Dialysis
• DME purchases under $250 and orthotics and prosthetics under $500
• Emergency or urgent care services
• Emergency transportation services
• Observation services will not require authorization; however preplanned procedures will be subject to outpatient authorization requirements
• Routine lab tests and X-ray services
• Select outpatient procedures

Please refer to the Quick Reference Guide and/or Authorization Lookup Tool to determine specific authorization requirements.

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

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

The second opinion must be provided at no cost to the Member by a qualified healthcare professional within network, or a non-participating Provider when a qualified Provider is not available in network.
Services for Special Populations
Members who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional conditions and who may require a broad range of primary, specialized medical, behavioral health, and/or related services may be identified as a Member with special healthcare needs. Members may be identified by the SCDHHS or by WellCare using an assessment tool.

Members may directly access a specialist as appropriate to the Member’s condition and identified needs.

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

An Emergency Medical Condition is:

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

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

It is WellCare’s policy that inpatient and outpatient emergency services are Covered Services that are:

• Furnished by a Provider qualified to furnish emergency services; and,
• Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency services are covered:

• Regardless of whether services are obtained within or outside the network of Providers available;
• Regardless of whether there is prior authorization for the services.

The attending emergency physician, or the Provider actually treating the Member, shall determine when the Member is sufficiently stabilized for transfer or discharge.
WellCare does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. WellCare will not refuse to cover emergency services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member’s PCP, WellCare or applicable state entity of the Member’s screening and treatment within 10 calendar days of presentation for emergency services. WellCare shall not deny payment for treatment when a representative of the entity instructs the Member to seek emergency services. Prior authorization is not required for treatment obtained when a Member had an emergency medical condition and the absence of immediate medical attention would have had the outcomes specified in 42 CFR 438.114 of the definition of emergency medical condition.

WellCare is responsible for payment to Providers in and out of the network, without requiring prior approval, for the following services and in accordance with the Social Security Act, Section 1867 (42 U.S.C. 1395 dd):

- Determining if an emergency exists for Members when the medical screening service is performed;
- Treatment as may be required to stabilize the medical condition;
- Transfer of the individual to another medical facility within Social Security Act Section 1867 (42 U.S.C. 1395 dd) guidelines and other applicable state and federal regulations;
- WellCare shall prior approve any services performed after the Provider, whether in- or out-of-network, has stabilized the patient. WellCare shall cover services subsequent to stabilization:
  - That were pre-approved by WellCare;
  - That were not pre-approved by WellCare because WellCare did not respond to the Provider of post-stabilization care services’ request for pre-approval within one hour after the request was made;
  - If WellCare could not be contacted for pre-approval; or
  - If WellCare and the treating physician cannot reach an agreement concerning the Member’s care and a network physician is not available for consultation. In this situation, WellCare shall give the treating physician the opportunity to consult with a network physician and the treatment physician may continue with the care of the Member until a network physician is reached or one of the criteria of 42 CFR 422.113(c)(3) is met.

A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

WellCare limits charges to Members for any post-stabilization care services to an amount no greater than what WellCare would charge the Member if he or she had obtained the services through one of WellCare’s Providers. WellCare’s financial responsibility for post-stabilization care services that it has not pre-approved ends when:
• A network physician with privileges at the treating hospital assumes responsibility for the Member’s care;
• A network physician assumes responsibility for the Member’s care through transfer;
• A representative of WellCare and the treating physician reach an agreement concerning the Member’s care; or
• The Member is discharged.

Once the Member’s condition is stabilized, unplanned urgent admissions must be followed by notification to WellCare by calling Provider Services and reporting the urgent or emergent admission within one business day of the admission. The caller should provide the following:

• Member’s name
• WellCare Member ID number
• Name of the admitting hospital
• Referring Provider
• Diagnosis of the Member

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

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

Post-stabilization services are services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve, or resolve the Member’s condition.

**Continuity of Care**

WellCare will allow Members in active treatment to continue care with a terminated or out-of-network 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.

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

For continued care under this provision, WellCare and the terminated Provider shall continue to abide by the same terms and conditions as existed in the terminated contract.
Transition of Care
During the first 30 days of enrollment, authorization is not required for certain Members with previously approved services by the 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 and without regard to whether such services are being provided within or outside WellCare’s network until such time as WellCare can reasonably transfer the Member to a service and/or network Provider without impeding service delivery that might be harmful to the Member’s health. However, notification to WellCare is necessary to properly document these services and determine any necessary follow-up care, including the coordination of services between setting of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. 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 disenrolled from WellCare and will transition to a Medicaid fee-for-service program or another managed care plan, a WellCare review nurse/care manager who is familiar with that Member will provide a transition of care report upon request to the receiving plan, or appropriate contact person for the designated fee-for-service program.

If a Provider receives an adverse claim determination they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals Department with documentation of approval for reconsideration. Refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

Services Covered by Medicaid Fee-for-Service
These services are covered by Medicaid fee-for-service (or the SCDHHS Medicaid Plan). For Members to receive these services, they will need to show their South Carolina Healthy Connections Medicaid ID card.

<table>
<thead>
<tr>
<th>Services Covered by SCDHHS</th>
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<tr>
<td>Certain behavioral health services:</td>
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<tr>
<td>• Targeted Case Management services</td>
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<tr>
<td>• Out-of-home therapeutic placement services for children</td>
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</tbody>
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WellCare of South Carolina, Inc.
Medicaid Provider Manual
Provider Services: 1-888-588-9842
Effective: August 12, 2019
## Services Covered by SCDHHS

### Dental services:
- Preventive, restorative and surgical services are covered for Members under age 21
- Emergency dental services are covered for Members over age 21
- SCDHHS is partnered with DentaQuest to provide dental care; call DentaQuest toll-free at 1-888-307-6552 (TTY/ 711) to:
  - Get more information about Covered Services
  - Find a Provider in your area
  - Make an appointment

### Developmental Evaluation Services (DES):
- These are Medically Necessary services for Members under age 21 who may have developmental delays, learning disabilities or other disabling conditions

### Family planning services through the Medicaid Adolescent Pregnancy Prevention Services (MAPPS) program:
- These services are for at-risk youths and include
  - Counseling
  - Education
- Services are provided in schools, office settings and homes

### Home- and community-based waiver services

### Non-emergency transportation

### Nursing home care after 90 consecutive days:
- WellCare covers the first 90 consecutive days

### Pregnancy prevention for targeted populations

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**Family Planning Services**

Family planning services are available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. Members have the freedom to receive family planning services outside WellCare’s network by appropriate Medicaid Providers without any
restrictions. For WellCare Members who elect to receive family planning services out-of-network, the Medicaid Provider will bill SCDHHS to be reimbursed by SCDHHS fee-for-service. Members should be encouraged to receive family planning services in-network to ensure continuity and coordination of care. Family planning services are provided in a manner that protects and enables the enrollee’s freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

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

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

An *Abortion Statement Form* must be properly executed and submitted to WellCare with the Provider’s claim. This form may be filled out and signed by the physician. The form is at [www.wellcare.com/South-Carolina/providers/Medicaid/Forms](http://www.wellcare.com/South-Carolina/providers/Medicaid/Forms).

Claims for payment may be denied for the physician only if the required consent is not attached or if incomplete or inaccurate documentation is submitted.

In addition to the above-mentioned documentation, WellCare also requires the submission of the History, Physical and Operative Report and the Pathology Report with all claims that have the following *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-10-CM) codes to ensure that abortions are not being billed through the use of other procedure codes.

**Sterilizations**

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

- Is under 21 years of age at the time she or he signs the consent
- Is not mentally competent
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility

A copy of the required *Consent for Sterilization (Form HHS 687)* is on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid/Forms](http://www.wellcare.com/South-Carolina/providers/Medicaid/Forms).

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

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is 30 calendar days.
The signed consent form expires 180 calendar days from the date of the Member's signature.

In the case of premature delivery or emergency abdominal surgery performed within 30 calendar days of signed consent, the physician 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.

A list of ICD-10-CM procedure codes associated with sterilization can be found in the Compliance Section of this Manual. All claims with procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the sterilization consent form is attached to those claims requiring a form.

**Hysterectomy**

Prior authorization is required for the administration of a hysterectomy to validate medical necessity as provided in 42 CFR §441.255 (2010, as amended). WellCare reimburses Providers for hysterectomy procedures only when the following requirements are met:

- The Provider ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- In the case of prior sterility or emergency hysterectomy, a Member is not required to sign the consent form, however a physician signature is required; and
- The Provider submits the properly executed Consent for Sterilization form at [www.wellcare.com/South-Carolina/providers/Medicaid/Forms](http://www.wellcare.com/South-Carolina/providers/Medicaid/Forms) with the claim prior to submission to WellCare.

Forms are located on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid/Forms](http://www.wellcare.com/South-Carolina/providers/Medicaid/Forms).

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

Subject to the terms of the Agreement, but 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.

A list of ICD-10-CM procedure codes associated with hysterectomies can be found in the Compliance Section of this Manual. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the hysterectomy...
acknowledgement form is attached. All hysterectomy codes listed require a hysterectomy acknowledgement form.

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

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of WellCare and the delegated entities.

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

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

On an annual basis, or more frequently, audits of the delegated entity are performed to ensure compliance with WellCare’s delegation requirements.

**Care Management Program**

WellCare utilizes a multi-disciplinary, Member-centered model that seamlessly integrates the delivery of care and services across all aspects of care management. The integrated care management model covers the full range of physical health, behavioral health, social and community based support of a Member in a coordinated and Member-centered manner. This model helps Members understand their overall health status, offer multiple channels for Member engagement, and embraces the empowerment of self-directed care while reflecting a shared responsibility between the Member, the primary care Provider and the plan.

Care management services are specifically designed to:

- Foster the relationship between our Member and their Primary Care Physician (medical home).
- Empower our Members to take control of their health by initiating and reinforcing healthy behaviors
- Help our Members obtain timely, effective, quality and culturally sensitive care
- Assist our Members with understanding and accessing their benefits to improve Member outcomes
• Collaborate with PCPs and specialists to coordinate care for the Member and expedite access to care and needed services.

WellCare identifies Members for care management services by health risk screenings, evidence-based criteria, risk stratification through data management, Member self-referral, direct referrals from primary care physicians and specialists, daily in-patient census reports and other internal referral sources. Once the Member is identified, the care manager determines whether a Member is appropriate for care management services by gathering and assessing relevant, comprehensive data. A nurse care manager (RN) or Licensed Clinical Social Worker (LCSW) will then complete a comprehensive assessment to identify medical, social, and/or behavioral healthcare needs. The care manager will develop and prioritize goals in collaboration with the Members and/or caregiver, the PCP and other Providers involved in the Member's care to address any identified gaps or barriers to care. The care manager will provide education, care coordination, advocacy services and facilitate appropriate utilization of available resources and services to optimize the Member’s health.

WellCare’s care management team also provides transitions of care management services to Member’s that are currently in-patient or have been recently discharged from an acute care facility. Care managers collaborate with facility Providers and primary care physicians to ensure the Member has a safe, timely and appropriate discharge plan.

Members commonly identified for WellCare’s Care Management Program include, but not limited to:

• Catastrophic injuries – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord and/or head injuries and burns.
• Multiple chronic conditions – One or more chronic conditions (or multiple co-morbid conditions) i.e., diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), HIV/AIDS and a recent exacerbation of one or more conditions that requires extensive coordination of needs.
• Transplantation – Organ failure, donor matching, pre-, post-transplant care.
• Complex needs – Members recently discharged home from acute inpatient or skilled nursing facility with multiple service and coordination needs (i.e., DME, PT/OT, home health), complicated, non-healing wounds, advanced illness, etc.
• Special healthcare needs – Children or adults who have serious medical or behavioral conditions or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities.
• Comprehensive care management services for pregnancy and post-partum care.
• NICU and NICU graduate care coordination through first year of life.
Disease Management Program

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

The Disease Management Program targets the following conditions:

- Asthma – adult and pediatric
- CAD
- CHF
- COPD
- Depression
- Diabetes – adult and pediatric
- Hypertension
- Smoking cessation
- Weight Management

WellCare's Disease Management Program educates Members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The program also focuses on educating the Provider with regard to the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of Members, improve health outcomes and decrease medical costs. Also, WellCare makes available to Providers and Members general information regarding health conditions on WellCare’s website at www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CCGs.

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

Interventions for Members identified vary, depending on their level of need and stratification level. Interventions are based on industry-recognized Clinical Practice Guidelines. Members identified at the highest stratification levels receive a comprehensive assessment by a disease management nurse, disease-specific educational materials, identification of a care plan and goals, and follow-up assessments to monitor adherence to the plan and attain goals. A plan is formulated for education interventions to meet Member goals and condition-specific program goals. These are mutually agreed upon goals of care with the Member and in some instances, the Member’s Provider. Members found to be at higher level of risk, particularly those
requiring coordination of services, such as Members transitioning from hospitalizations, are transferred to our Care Management Department, which specializes in the coordination of Members support services. Members identified during the assessment process with HIV/AIDS are referred to care management to assess for further coordination of needs. Members identified with depression are also referred to behavioral health for follow-up.

Disease-specific *Clinical Practice Guidelines* adopted by WellCare are on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CPGs](http://www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CPGs).

**Access to Care and Disease Management Programs**

To refer a WellCare Member as a potential candidate to the Care Management or Disease Management Programs, or to receive more information about either of these programs, Providers may call the WellCare Care Management Referral Line, or complete and fax a request to the number on the Quick Reference Guide. Members may self-refer by calling the Care Management toll-free line or the Nurse Advice Line after hours or on weekends (TTY/ available).

For more information on the Care Management Referral Line, refer to the Quick Reference Guide at [www.wellcare.com/South-Carolina/providers/Medicaid/](http://www.wellcare.com/South-Carolina/providers/Medicaid/).
Section 5: Claims

Overview
The focus of WellCare’s Claims Department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for Providers to access a representative in our Customer Service Department. For more information, refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process
WellCare (in partnership with PaySpan) has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) Services. Once registered, this no-cost secure service offers Providers a number of options for viewing and receiving remittance details, ERAs can be imported directly into practice management or patient accounting system, eliminating the need to rekey remittance data. Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will no longer receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from PaySpan’s website, once registration is completed. Providers can register using PaySpan’s enhanced Provider registration process at payspan.com. PaySpan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the Web at payspanhealth.com.

Timely Claims Submission
Unless otherwise stated in the Provider Agreement, Providers must submit clean claims to WellCare within 180 days of service date for outpatient services or the date of discharge for inpatient services. If the Member has Medicare as primary carrier, claims must be received within 180 days from the Medicare carrier’s EOB date, or 365 days from DOS, whichever is later. Unless prohibited by federal law or CMS, WellCare may deny payment for any claims that fail to meet WellCare’s submission requirements for clean claims, or that are received after the time limit in the Provider Agreement for filing clean claims.

The following items can be accepted as proof that a claim was submitted timely:

- The date the claim was electronically accepted by WellCare as indicated on a clearinghouse electronic acknowledgement; and
- The date indicated on a Provider’s electronic submission sheet with all the following identifiers: patient name, Provider name, date of service to match Explanation of Benefit (EOB)/claim(s) in question, prior submission bill dates, and WellCare product name or line of business.

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

**Tax Identification and National Provider Identifier Requirements**
WellCare requires the payer-issued Tax ID and NPI on all claims submissions, 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/or NPI. More information on NPI requirements, including HIPAA’s NPI Final Rule Administrative Simplification, is available on the CMS website at [www.cms.gov](http://www.cms.gov).

**Taxonomy**
Providers are encouraged to submit claims with the correct taxonomy code consistent with Provider’s specialty, and services being rendered, in order to increase appropriate adjudication. WellCare will reject the claim if the taxonomy code is omitted and may reject the claim if the taxonomy code is incorrect.

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

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

**Strategic National Implementation Process**
All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines. The SNIP validations used by WellCare to verify transaction integrity/syntax are available on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid/Claims](http://www.wellcare.com/South-Carolina/providers/Medicaid/Claims).

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

**Claims Submission Requirements**
WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare requires all diagnosis coding to be ICD-10, or its successor. In addition, CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) are required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the Provider must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.
WellCare tracks billing codes and Providers who continue to apply incorrect coding rules. Providers may be educated on the proper use of codes as part of the retrospective review process. Should a Provider continue to repeat the inappropriate coding practice, the Provider may 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. Providers using paper submissions shall submit all claims to WellCare or its designee, as applicable, using CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider’s NPI, Tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the Member’s medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member expenses and/or non-covered services. For more information on submission of claims, refer to the Quick Reference Guide at www.wellcare.com/South-Carolina/providers/Medicaid.

For more information on Covered Services under WellCare’s South Carolina Medicaid plans, refer to WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

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 at www.wellcare.com/South-Carolina/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 clearinghouses, refer to the Provider Resource Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

A unique WellCare Payer ID is included in the welcome letter from WellCare. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on the WellCare Payer IDs or to contact WellCare’s EDI team, refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

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

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

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

**Paper Claims Submissions**

For more timely processing, Providers are encouraged to submit claims electronically. For assistance in creating an EDI process, contact WellCare’s EDI team by referring to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

If permitted under the Provider 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 original (red ink on white paper) claim forms;
- Any missing, illegible, incomplete, or invalid information in any field will cause the claim to be rejected or processed incorrectly;
- Per CMS guidelines, the following process should be used for clean claims submission:
  - The information must be aligned within the data fields and must be:
    - On an original red ink on white paper claim form
    - Typed – do not print, handwrite, or stamp any extraneous data on the form
    - In black ink
    - In large, dark font such as PICA, ARIAL 10-, 11- or 12-point type
    - In capital letters
  - The typed information must not have:
    - Broken characters
    - Script, italics or stylized font
    - Red ink
    - Mini font
    - Dot matrix font

**CMS Fact Sheet about UB-04**

Claims Processing

Pre-payment Equian Forensic Review
WellCare has retained Equian, LLC (“Equian”) to assist with its claim adjudication obligations. Equian will apply WellCare’s policies and procedures for claims payment when performing its reviews. During its claim adjudication review, Equian may identify line items that require additional information/clarification before they can be adjudicated on their merits.

If Equian identifies billing issues during its adjudication review, you will: a) receive from Equian a Forensic Review Report that identifies each of the line items in question and clarification of the issues affecting these line items, and b) receive from WellCare payment in full for all charges that are not in question. WellCare has asked that Equian work with you to obtain the additional information and clarification necessary to resolve any issues involving charges that you believe are payable as billed.

The Forensic Review Report provides direct contact information for the Equian team member assigned to the underlying claim. Please contact the Equian Resolution team member directly to discuss any questions or issues you may have regarding the Forensic Review Report’s findings.

Alternatively, your facility may formally appeal the Forensic Review Report’s findings. Please assure that any such correspondence clearly indicates that it is, in fact, a formal appeal and includes all explanations and documentation necessary to address the issues raised in the Forensic Review Report. Please submit the appeal directly to Equian at the following address:

Equian, LLC
ATTENTION: Appeals Department
300 Union Blvd., Suite 200
Lakewood, CO 80228

72-Hour Rule
WellCare will not reimburse outpatient services provided within the three days prior to an inpatient admission (including but not limited to: outpatient services followed by admission before midnight of the following day, preadmission diagnostic services, and other preadmission services). WellCare will apply this policy regardless of the status of the outpatient Provider/facility, and includes but not limited to preadmission services performed by an outpatient Provider/facility who (i) is the same as the inpatient Provider/facility; (ii) is an affiliate of the inpatient Provider/facility; (iii) bills under the same tax identification number as the inpatient Provider/facility; (iv) is part of the same hospital system/facility as the inpatient Provider; or (v) is owned by the same corporate parent as the inpatient Provider/facility.
Disclosure of Coding Edits
WellCare uses claims editing software programs to assist in determining proper coding for Provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and state-specific regulations. These software programs may result in claim edits for specific procedure code combinations. These claims editing software programs may result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission for review of health records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to WellCare. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

Prompt Payment
WellCare will pay Clean Claims in accordance with the terms of the Provider Agreement.

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 shall follow WellCare policies and procedures regarding subrogation activity.

Encounters Data

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

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

**Accurate Encounters Submission**

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. Once WellCare receives delegated encounters from vendors or Providers, 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 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/South-Carolina/providers/Medicaid/Claims) on WellCare’s website.

Vendors are required to comply with any additional encounter validations as defined by the states and/or CMS, including under 42 CFR §438.818.

**Encounters Submission Methods**

Delegated vendors and Providers may submit encounters electronically, through WellCare’s contracted clearinghouse(s), via DDE, or using WellCare’s Secure File Transfer Protocol (SFTP) 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 Healthcare 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 [www.wellcare.com/South-Carolina/providers/Medicaid/Claims](http://www.wellcare.com/South-Carolina/providers/Medicaid/Claims).

A unique WellCare Payer ID is included in the welcome letter. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on the WellCare Payer IDs or to contact WellCare’s EDI team, refer to the [Quick Reference Guide](http://www.wellcare.com/South-Carolina/providers/Medicaid) on WellCare’s website.

**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 is on the Provider Portal at [southcarolina.wellcare.com/login/provider](http://southcarolina.wellcare.com/login/provider). For more information on no-cost DDE
options, refer to the Provider Resource Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

Encounters Data Types
There are four encounter types that delegated vendors and Providers are required to submit as encounter records. 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

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 E – an encounter that has never been submitted to WellCare previously.
- Voided E – an encounter that WellCare deletes from the encounter file and is not submitted to the state.
- Replaced or OE – 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 Agreement. Payment made to Providers constitutes payment-in-full by WellCare for covered benefits, with the exception of Member expenses. For Covered Services, Providers shall not balance bill Members any amount in excess of the contracted amount in the Provider Agreement. An adjustment in payment because 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.

Provider Preventable Conditions
WellCare follows CMS guidelines regarding “Hospital Acquired Conditions,” “Never Events,” and other “Provider Preventable Conditions (PPCs).” Under Section 42 CFR 434, 438, and 447 these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

- A different procedure altogether;
- The correct procedure, but on the wrong body part; or
- The correct procedure, but on the wrong patient.
Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html) and include such events as an air embolism, falls, and catheter-associated urinary tract infection.

Healthcare 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.

**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 initiated within 30 days of WellCare’s EOP or the time frame specified in your contract.

Documentation consists of:

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

To initiate the process, refer to the *Quick Reference Guide* located on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid](http://www.wellcare.com/South-Carolina/providers/Medicaid).

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

To submit a corrected or voided claim electronically:

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

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

- 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 side of Box 22.

Example:

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

Please note: If “Corrected Claim” is handwritten, stamped, or typed on the claim form without entering the appropriate frequency code 7 or 8 along with the Original Reference Number as indicated above, the claim will be considered a first-time claim submission.

The correction or void process involves two transactions:

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

**Reimbursement**
If there is no site-of-service payment differentials specified on the South Carolina Medicaid website, WellCare applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes, based on the place of treatment (physician office services vs. other places of treatment).

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

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

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

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

- **Multiple Procedures**: Payment for multiple procedures is based on current CMS methodologies. When multiple surgeries are performed in a single session, reimbursement for facility services will be 100% of the surgical group rate for the primary procedure, and 50% of the surgical group rate for the secondary and/or tertiary procedures. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.
  - According to the *Ambulatory Surgical Centers Manual*, Transmittal #6 page 5.2, when multiple surgeries are performed in a single session, reimbursement for facility services will be 100% of the surgical group rate for the primary procedure, and 50% of the surgical group rate for the secondary.

- **Assistant Surgeon**: If there are no reimbursement guidelines on the South Carolina Medicaid website for payment of assistant-at-surgery services, payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages and methodologies.
- **Co-Surgeon:** If there are no reimbursement guidelines on the South Carolina Medicaid website for payment of co-surgery procedures, payment for a co-surgeon is based on current CMS percentages and methodologies. In these cases, each surgeon should report his or her distinct, operative work, by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier “62” added.

**Modifier**

If there are no reimbursement guidelines specific to a modifier(s) on the South Carolina Medicaid website, WellCare follows CMS guidelines regarding modifiers and only reimburses modifiers that are reimbursable by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

**Allied Provider**

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

**Overpayment Recovery**

WellCare strives for 100% payment quality, but recognizes that a small percent of financial overpayments may occur while processing claims. An overpayment can occur due to reasons such as retroactive Member termination, inappropriate coding, duplication of payments, non-authorized services, and other reasons.

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment causes an overpayment, WellCare will adhere to South Carolina Title 38, Chapter 59, Section 38-59-250, and limit its notice of overpayment recovery to 18 months from the initial payment date. WellCare or its designee will provide a written notice to the Provider identifying the specific claims, overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment recovery notice 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, request further information or appeal or dispute the retroactive denial.

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

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

For more information on contacting WellCare Provider Services, refer to the Quick Reference Guide at www.wellcare.com/South-Carolina/providers/Medicaid.

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

Overview
Credentialing is the process by which the appropriate peer review bodies of WellCare evaluate the credentials and training qualifications of practitioners, including without limitation physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations. For purposes of this Credentialing section, all references to “practitioners” shall include Providers delivering health or health-related services, including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare 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 healthcare
- Accreditation status, as applicable to non-individuals

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

Providers are responsible for providing WellCare all of their relevant credentialing information and documentation required for WellCare’s credentialing application process, which utilizes the current NCQA Standards and Guidelines for the accreditation of Medicaid Managed Care Organizations for the successful credentialing and re-credentialing of licensed practitioners. The practitioner credentialing application must be attested to by the applicant as being true, accurate 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 List of Excluded Individuals and Entities (LEIE), maintained by the Office of Inspector General (OIG); System for
Award Management (SAM); National Practitioner Data Bank (NPDB); American Medical Association (AMA) Physician Master File entry, State Medicaid Agency; and SC Excluded Providers List.

- Physicians, allied health professionals and ancillary facilities/healthcare delivery organizations must be credentialed to be network Providers of services to WellCare Members.
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.

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

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

**Practitioner Rights**

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

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

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

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

The practitioner may review documentation submitted by him or her in support of the credentialing/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies, and certification boards, subject to any WellCare restrictions. WellCare, or its designee, will review the corrected information and explanation at the time of considering the practitioner’s credentials for Provider network participation or re-credentialing.

The Provider may not access peer review information obtained by WellCare.
Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame
In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by WellCare, the practitioner has the right to review the information that was submitted in support of her or his application, and has the right to correct the erroneous information. WellCare will provide written notification to the practitioner of the discrepant information.

WellCare’s written notification to the practitioner includes:

- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;
- The addressee in credentialing to whom corrections must be sent;
- WellCare’s documentation process for receiving the correction information from the Provider; and
- WellCare’s review process.

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

License to Practice – Providers must have a current, valid, unrestricted license to practice and such license shall be in good standing with the state.

Drug Enforcement Administration Certificate – Providers must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current 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 – Providers must provide a minimum of five years of relevant work history as a health professional.

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

Hospital-Admitting Privileges – Specialist Providers shall have hospital-admitting privileges at a WellCare participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another WellCare participating Provider who has admitting privileges at a WellCare participating hospital for the admission of Members.
Ability to Participate in Medicaid – Providers must have the ability to participate in Medicaid. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare Company Plan. In order to participate with WellCare of South Carolina, a Provider must complete a participation agreement and submit all necessary credentialing information. Providers are not eligible for participation if the Provider owes money to the Medicaid program or if the Office of the Attorney General has an active fraud investigation involving the Provider. Existing Providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with WellCare policies and procedures.

At the time of initial credentialing, WellCare reviews the state-specific opt-out listing maintained on the designated state carrier’s website to determine whether a Provider has opted out of Medicare. WellCare monitors the opt-out website on an ongoing basis.

Liability Insurance
WellCare Providers (all disciplines) are required to carry and continue to maintain professional liability insurance and commercial general liability (CGL) with appropriate coverage limits, as determined by WellCare. Providers must furnish copies of current professional liability insurance certificates 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
  - Posting of office hours
  - Availability of appointments
- Medical/treatment record-keeping criteria

SIEs are conducted for:

- Unaccredited facilities
- State-specific re-credentialing requirements
- When a grievance is received relative to office site criteria

SIE’s required as a result of a valid complaint will be completed within 45 days. SIEs are conducted for those sites where a grievance is received relative to office site criteria listed above. SIEs may be performed for an individual grievance 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 Practice Registered Nurses (APRN)
  - APRNs acting as a PCP must maintain a collaborative agreement to include written protocols with participating supervising physicians
- Certified Nurse Midwives (CNM)
- PAs
- Osteopathic Assistants (OA)

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

- Licensed clinical social workers
- Licensed mental health counselors
- Licensed marriage and family therapists
- Physical therapists
- Occupational therapists
- Audiologists
- Speech/language therapist/pathologists

Ancillary Healthcare Delivery Organizations
Ancillary and organizational applicants must complete a credentialing application and, as applicable, undergo an SIE if unaccredited. WellCare is required to verify accreditation, licensure, Medicaid certification (as applicable), regulatory status and liability insurance coverage prior to considering the applicant for participation as an in-network Provider with WellCare.

Licensure Requirements
The following are minimum licensing requirements by practitioner type and such requirements are not all inclusive and are subject to change to comply with applicable Laws, Governmental Authorities, and accreditation standards:

- Inpatient/Outpatient hospital Providers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by CMS.
- Ambulatory surgical centers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by CMS.
- End stage renal disease clinics must be surveyed and licensed by DHEC, and certified by the CMS.
• Laboratory testing facilities providing services must have a CLIA Certificate of Waiver, or a Certificate of Registration with a CLIA identification number per federal regulations. Laboratories can only provide services consistent with their type of CLIA certification.

• Infusion Centers have no licensing or certification requirements.

• Medical professionals to include, but not limited to physicians, physician’s assistants, certified nurse midwives/ licensed midwives, certified registered nurse anesthetists (CRNAs)/ anesthesiologist assistants (AAs), nurse practitioners/ clinical nurse specialists, podiatrists, chiropractors, private therapists and audiologists must all be licensed and certified to practice by the appropriate Board/ Licensing body (i.e., Board of Medical Examiners, Board of Nursing, Council on Certification of Nurse Anesthetists, Board of Podiatry Examiners, Board of Chiropractic Examiners, Board of Occupational Therapy, Board of Physical Therapy, Board of Examiners in Speech Language Pathology and Audiology).

• Federally Qualified Health Clinics (FQHCs) must have a Notice of Grant Award under 319, 330 or 340 of the Public Health Services Act and be certified by CMS. FQHCs billing laboratory procedures must have a CLIA certificate.

• Rural Health Clinics (RHCs) must be surveyed and licensed by DHEC and certified by CMS. RHCs billing laboratory procedures must have a CLIA Certificate. Laboratories can only provide services that are consistent with their type of CLIA certification.

• Alcohol and Substance Abuse clinics are required to be licensed by DHEC.

• Mental health clinics must be a Department of Mental Health (DMH) sanctioned Community Mental Health Center. Out-of-state Providers must furnish proof of Medicaid participation in the State in which they are located.

• Portable X-ray Providers must be surveyed by DHEC and certified by CMS.

• Stationary X-ray equipment must be registered with DHEC.

• Mobile ultrasounds require no license or certification.

• Physiology lab Providers must be enrolled with Medicare.

• Mammography service facilities providing screening and diagnostic mammography services must be certified by the USDHHS, Public Health Services, and the Food and Drug Administration (FDA).

• Mail order pharmacy Providers must be licensed by the appropriate state board. Additionally, a special non-resident South Carolina Permit Number is required for all out-of-state Providers. Such permits are issued by the Board of Pharmacy, under the South Carolina Department of Labor, Licensing and Regulations.

• Ambulance transportation service Providers must be licensed by DHEC.
• Home health service Providers must be surveyed and licensed by DHEC and certified by CMS.

• Long-term care facilities/nursing homes must be surveyed and licensed under State law and certified as meeting the Medicaid and Medicare requirements of participation by DHEC.

• For all state agencies and organizations, including the Department of Alcohol and Other Drug Abuse, the South Carolina Department of Mental Health, the Department of Social Services, the Department of Health and Environmental Control, and the Department of Disabilities and Special Needs, WellCare will credential the state agency/organization because they are the Provider of record. The state agency/organization is responsible for screening and exclusions for any employees utilized for service provision.

**Re-Credentialing**
In accordance with regulatory and accreditation requirements, and WellCare policy and procedure, re-credentialing is required every three years. A notice will be sent by mail that contains a printed re-credentialing application and instructions 180 days before a Provider’s three-year re-credentialing due date.

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

**Medicare/Medicaid Sanctions Report**
On a monthly basis, WellCare or its designee accesses the listings from the List of Excluded Individuals and Entities (LEIE), maintained by the Office of Inspector General (OIG); System for Award Management (SAM); National Practitioner Data Bank (NPDB); American Medical Association (AMA) Physician Master File entry; State Medicaid Agency; and SC Excluded Providers List for the most current available information. This information is crosschecked against the network of Providers. If Providers are identified as sanctioned, such Providers are subject to immediate termination and notification of termination of contract, in accordance with WellCare policies and procedures and the Provider Agreement.

**Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials**
On a monthly basis, WellCare or its designee contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is crosschecked against the network of WellCare Providers. If a network Provider is identified as 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 the Provider Agreement 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 determines whether the Provider should continue participation or whether termination should be initiated.

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

WellCare may immediately suspend, pending investigation, the participation status of a participating Provider who, in the opinion of the medical director, is or has 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. If WellCare alters the conditions of participation of a Provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

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

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

The following actions by WellCare entitle the practitioner affected to the Provider Dispute Resolution Peer Review Panel process:

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

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

The practitioner has a period of up to 30 days in which to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review Panel process.
Upon timely receipt of the request, the medical director or 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.

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

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

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

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

**Delegated Entities**

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

Appeals Process

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

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

Upon receipt of all required documentation, WellCare has 30 calendar days to review the appeal for medical necessity and conformity to WellCare guidelines, and to render a decision to reverse or affirm. To the extent additional information is required to render a decision, the Provider agrees to grant WellCare a 15-day extension upon WellCare’s request. If the Provider requests the extension, the extension shall be approved by WellCare.

Appeals received without the necessary documentation may be denied for lack of information. Records and documents received after that time frame will not be reviewed and the appeal will remain closed.

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

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

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

Affirmation of Denial
If it is determined during the review that the Provider did not comply with WellCare protocols and/or medical necessity was not established, the denial will be 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 letter. The Provider may also request a copy of the benefit provision, guideline, protocol and other similar criteria used in making the appeal decision, by sending a written request to the appeals addresses listed in the decision letter.

**Member Appeals Process**

**Overview**

A Member appeal is a formal request from a Member for a review of an Adverse Benefit Determination taken by WellCare. An appeal may also be filed on the Member’s behalf by an authorized representative or a Provider with the Member’s written consent. It is not necessary for the Provider to submit this written permission when requesting an appeal on behalf of the Member. All appeal rights that apply to Members, as described in Section 7 of this Provider Manual, will also apply to the Member’s authorized representative, or to a Provider acting on behalf of the Member with the Member’s written consent. To appeal, the Member may file an appeal request either orally via WellCare’s Customer Service or in writing within 60 calendar days from the date on the notice of Adverse Benefit Determination letter. There is only one level of appeal with the Plan.

If an appeal is filed orally via WellCare’s Customer Service, the request must be followed up with a written, signed appeal to WellCare. For oral filings, the time frames for resolution begin on the date the oral filing was received by WellCare. Unless written confirmation of a standard oral appeal request is received, the appeal is closed as an invalid appeal and a decision is not made on the appeal.

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

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for service;
- The failure to provide services in a timely manner, as defined by the appropriate department;
- The failure of WellCare to complete the authorization request in a timely manner as defined in 42 CFR 438.408; and
- For a resident of a rural area with only one plan, the denial of a Member’s request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.
- The denial of an enrollee’s request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

If the Member’s request for appeal is submitted after 60 calendar days from the date on the notice of Adverse Benefit Determination, 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:
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- The Member did not personally receive the notice of Adverse Benefit Determination or received the notice late;
- The Member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the Member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits; and/or
- The Member had incorrect or incomplete information concerning the appeal process.

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

WellCare ensures that the decision-makers assigned to appeals are not involved in previous levels of review or decision-making nor a subordinate of any such individual. When deciding an appeal of a denial based on lack of medical necessity, or a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the appeal reviewers will be healthcare professionals with clinical expertise in treating the Member’s condition/disease, or will have sought advice from Providers with expertise in the field of medicine related to the request.

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

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

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

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

Only pre-service appeals may be expedited.

**Appointment of Representative**
If the Member wishes to use a representative, then she or he must submit a written statement or the Member may complete an Appointment of Representative (AOR) statement. The Member and the person who will be representing the Member must sign the AOR statement. The form is located on WellCare’s website at
Appeal Decision Time Frames
WellCare must make a determination from the receipt of the request on a Member appeal and notify the appropriate party within the following time frames:

- Standard Pre-Service and Retrospective Appeals Request: 30 calendar days from the date Health Plan receives the appeal request
- Acknowledgment of Appeal: 5 business days from the date the Health Plan receives the appeal request
- Expedited Request: 72 Hours from the date the Health Plan receives the appeal request

The standard pre-service, expedited, and retrospective determination periods noted above may be extended by up to 14 calendar days if the Member requests an extension or if WellCare justifies a need for additional information and documents how the extension is in the interest of the Member. If an extension is not requested by the Member, WellCare will make reasonable efforts to give the Member prompt oral notice of the delay and provide the Member with written notice of the reason for the delay within two calendar days of the decision to extend the time frame and inform the Member of the right to file a grievance if he or she disagrees with the decision for an extension.

If the Health Plan fails to adhere to the notice and timing requirements in this section, the Member is deemed to have exhausted the Plan’s internal appeals process and may initiate a State fair hearing.

Standard Pre-Service and Retrospective Appeals Process
A Member may file a standard pre-service or retrospective appeal determination. After filing a written appeal, a Member may provide additional information to support their appeal, present his or her appeal in person, and request to review their records at any time during the appeals process. Upon the receipt of a request for appeal, written acknowledgment will be issued within five business days stating that the appeal was received.

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

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

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

**Expedited Appeals Process**

To request an expedited appeal, a Member or a Provider (regardless of whether the Provider is affiliated with WellCare) must submit an oral or written request directly to WellCare. A request to expedite an appeal determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member’s life, health, or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision. A Member may present his or her appeal in person, and request to review their records. The time frame to submit additional information or to review the case file may be limited for expedited appeal files.

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

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

WellCare will provide the Member with prompt oral notification within 24 hours regarding the denial of an expedited request and will follow-up with oral notification of the decision and mail a letter to the Members within two calendar days, which:

- Explains that WellCare will automatically transfer and process the request using the 30-calendar day time frame for standard appeals beginning on the date WellCare received the original request.

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

WellCare may extend the expedited review time period by up to fourteen (14) calendar days if the Medicaid Managed Care Member requests an extension, or if the CONTRACTOR justifies (to the Department upon request) a need for additional information and how the extension is in the Medicaid Managed Care Member’s interest. If an extension is not requested by the Member, WellCare will make reasonable efforts to give the Member prompt oral notice of the delay and provide the Member with written notice of the reason for the delay within two calendar days of the decision to extend the time frame and inform the Member of the right to file a grievance if he or she disagrees with the decision for an extension.
If WellCare reverses its initial action and/or the denial, it will issue an authorization to cover the requested service, and notify the Member orally within 72 hours of receipt of the expedited appeal request, followed with written notification of the appeal decision.

**Denial of an Expedited Appeal Request**

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

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

**State Fair Hearing for Members**

If a Member has exhausted the Health Plan’s appeal process, the Member may request a State Fair Hearing with the SCDHHS within 120 calendar days from date on the Health Plan’s Notice of Appeal resolution, if he or she is dissatisfied with an action that has been taken by WellCare.

If Health Plan fails to adhere to the notice and timing requirements for the appeals process, the Member is deemed to have exhausted the Health Plan’s internal appeals process and may initiate a State Fair Hearing.

The State’s standard time frame for reaching its decision will be within 90 calendar days from the date the Member filed the appeal with the contracting, excluding any days to file the request for a Fair Hearing.

A Member may request an expedited Fair Hearing decision from the State. SCDHHS will grant or deny these requests as quickly as possible as the Member’s health condition requires, but no later than three business days from the state’s receipt of the Member’s request and to the extent the request meets the state’s criteria for expedited review. If the State denies the request to expedite review, the hearing (appeal) will follow the standard 90-day time frame.

SCDHHS may grant expedited review if they determine the standard appeal time frame could jeopardize the individual’s life, health, or ability to attain, maintain, or regain maximum function. SCDHHS may consider, among other facts:

- The medical urgency of the beneficiary’s situation
- Whether a needed procedure has already been scheduled
• Whether a beneficiary is unable to schedule a needed procedure due to lack of coverage
• Whether other insurance will cover most of the costs of the requested treatment.

The Member may request an expedited State Fair Hearing at the same time the Member files the State Fair Hearing request or after filing a State Fair Hearing request. The Member must state they are seeking an expedited Fair Hearing and explain why.

To avoid delays in the process, Members should submit any supporting documentation with the request for expedited review or immediately thereafter. While supporting documentation is not required, SCDHHS will make its determination based on the information made available at the time they consider the request.

**Continuation of Benefits While the Appeal and State Fair Hearing are Pending**

The request for continuation of benefits must be filed within 10 calendar days of the date of the Notice of Adverse Benefit Determination, or the intended effective date of WellCare’s proposed Action, in order to be considered timely.

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

a. The Member or the service Provider files a timely appeal of the Health Plan’s action;
b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
c. The services were ordered by an authorized Provider;
d. The original period covered by the original authorization has not expired; and
e. The Member requests extension of the benefits.

If the Member requests the Health Plan continues or reinstates the Member’s benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

a. The Member withdraws the appeal
b. Ten calendar days have passed after the Health Plan mailed the notice providing the resolution of the appeal against the Member, unless the Member, within the 10-day time frame, has requested a State Fair Hearing with continuation of benefits until a decision is reached.
c. A State Fair Hearing Officer issues a hearing decision adverse to the Member.
d. The time period or service limits of a previously authorized service has been met.

If the State Fair Hearing is decided in the Member’s favor, WellCare will approve and pay for the care that is needed as quickly as possible but no later than 72 hours from the date it receives notice reversing the determination (if the Member didn’t receive the care during the review of the case).
The Member may be liable for the cost of any continued benefits at the discretion of WellCare or the SCDHHS.

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

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

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

**Grievance Process**

**Provider**
Providers may file a grievance only on behalf of the Member as the Member’s authorized representative, to the extent permitted by state Law and only with the Member’s written consent.

WellCare will give all Providers written notice of the grievance procedures when they become participating Providers.

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

**Member**
A Member, or Member’s representative acting on the Member’s behalf, may file a grievance at any time after the date of the dissatisfaction.

Examples of grievances that can be submitted include, but are not limited to:

- **Provider service including, but not limited to:**
  - Rudeness by Provider or office staff
  - Failure to respect the Member’s rights
  - Quality of care/services provided
  - Refusal to see Member (other than in the case of patient discharge from office)
  - Office conditions
- **Services provided by WellCare including, but not limited to:**
  - Hold time on the telephone
  - Rudeness of staff
  - Involuntary disenrollment from WellCare
  - Unfulfilled requests
• Access availability including, but not limited to:
  o Difficulty getting an appointment
  o Wait time in excess of one hour
  o Handicap accessibility

WellCare will acknowledge the Member grievance in writing within five business days from the date the grievance is received by WellCare. The acknowledgement letter will include:

• The name and telephone number of the Grievance Coordinator; and
• The expected date of the grievance resolution.

Upon receipt of the grievance, if additional information is required, the Member will receive a letter within five business days that will serve as acknowledgment of the grievance and a request for additional information.

A written resolution letter of the disposition of the grievance will be mailed to the Member within 90 calendar days from the date the grievance is received by WellCare. This resolution letter will not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent. In that case, one letter will be sent which includes both the acknowledgement and the decision letter. The resolution letter will include:

• The results/findings of the resolution
• Any action taken
• The substance of the grievance
• All information considered in the investigation of the grievance
• The date of the grievance resolution

The standard grievance review period 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, and how the extension is in the best interest of the Member. If WellCare extends the Member’s grievance resolution, the Member will be notified orally and in writing, including the reason for the delay within two calendar days.

Second Level Review (Appeal) of the original decision
When the Member is notified of WellCare’s resolution, if the Member is not satisfied with the resolution regarding adverse decisions that affect the Member’s ability to receive benefit coverage, access to care, access to services or payment for care of services, the Member may request a second-level review with WellCare. The second-level grievance review may be filed within 30 days of receiving your resolution letter and will follow the same process and procedures outlined for the initial review, but will be performed by person(s) not involved in the initial review. If the grievance resolution includes or/is regarding an appealable action the appropriate department (utilization management/claims) will provide resolution and issue a notice of Adverse Benefit
Determination, with the Member’s right to appeal as appropriate. This decision will outline and provide the Member’s rights to the appeal process.

WellCare will ensure that no punitive action is taken against a Provider who, as an authorized representative, files a grievance on behalf of a Member, or supports a grievance filed by a Member. Documentation regarding the grievance will be made available to the Member, if requested.

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

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

Grievance Submission
An oral grievance request can be filed through the established toll-free number to the WellCare Customer Service Department. The State of South Carolina allows Members to file a grievance at any time with WellCare regarding the event that caused the dissatisfaction. WellCare has 90 calendar days to resolve the Member’s grievance. An oral request may be followed up with a written request by the Member, but the time frame for resolution begins the date the oral filing is received by WellCare. A written Member grievance can be mailed directly to WellCare’s Grievance Department at:

WellCare of South Carolina
Attention: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

For the submission address, telephone and fax numbers, please refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.
Section 8: Compliance

WellCare Compliance Program

WellCare maintains a Corporate Compliance Program (Compliance Program) that promotes ethical conduct in all aspects of the company's operations, and ensures compliance with WellCare policies, and applicable federal and state regulations. The Compliance Program includes information regarding WellCare’s policies and procedures related to fraud, waste and abuse, and provides guidance and oversight regarding the performance of work by WellCare, WellCare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All Providers, including the Provider’s employees and sub-contractors and their employees, are required to comply with WellCare’s Corporate Compliance Program requirements.

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 diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor. All Providers must submit HIPAA compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at www.cms.gov, and the ICD-10 Lookup Tool at www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx for specific codes.

Information on ICD-10 transition and codes can also be found at www.wellcare.com/South-Carolina/providers/ICD10-Compliance. WellCare’s compliance training requirements include, but are not limited to:

- Compliance Program Training
  - To ensure policies, procedures and related compliance concerns are clearly understood and followed; and
  - To provide a mechanism to report suspected violations and implement disciplinary actions to address violations.
  - HIPAA Privacy and Security Training which encompasses privacy and security requirements in accordance with the federal standards established pursuant to HIPAA, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act; and
  - Must include, but is not limited to:
    - Uses and disclosures of Protected Health Information;
    - Member rights; and
    - Physical and technical safeguards.

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

- Cultural Competency Training
  - Programs to educate and identify the diverse cultural and linguistic needs of the Members that the Providers serve.

- Disaster Recovery and Business Continuity
  - Development of a business continuity plan that includes the documented process of continued operations of delegated functions in the event of a short-term or long-term interruption of services.

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 FWA Hotline at 1-866-678-8355.

Details of the corporate ethics and compliance program may be found on WellCare’s website at www.wellcare.com/South-Carolina/Corporate/Compliance.

**Code of Conduct and Business Ethics**

**Overview**

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

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

WellCare is committed to the prevention, detection and reporting of healthcare 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 to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of healthcare service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement and WellCare vigorously investigate incidents of suspected FWA. Providers are cautioned that unbundling, fragmenting, up-coding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD-CM), Physicians’ Current Procedural Terminology (CPT) 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.

Over the past several years, WellCare has been implementing claim coding payment policies that reflect guidelines set forth by industry authorities. Our goal is to process claims consistently and in accordance with best practice standards. Providers will receive notification that a claim coding error was detected based on edits that include, but are not limited to AMA, CMS, FDA and state Medicaid guidelines. This includes high dollar claims, unbundled procedures, modifiers, correct coding initiatives edits, duplicates, maximum units, multiple surgeries and bilateral procedures.

In addition, Providers are reminded that health 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 fraud, waste and abuse. To meet federal regulation standards specific to fraud, waste and abuse (42 CFR § 423.504), Providers and their employees must complete an annual fraud, waste and abuse training program.

**Ways to report suspicion of Fraud, Waste and Abuse:**

- The South Carolina Department of Health and Human Services (SCDHHS) encourages Providers who suspect fraud of the Medicaid program to report it via one of the following methods:
Confidentiality of Member Information and Release of Records

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

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

Some examples of confidential information include:

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

Refer to Section 3: Quality Improvement for guidance in responding to WellCare’s requests for Member health records for the purposes of treatment, payment and healthcare activities.

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

For more information on how to request this information, Members may call WellCare’s Customer Service using the toll-free telephone number on the Member ID card. Providers may contact WellCare’s Provider Services by referring to the Quick Reference Guide at www.wellcare.com/South-Carolina/providers/Medicaid.

Provider Education and Outreach
Providers may:

• Display state-approved, WellCare-specific materials in-office;
• Announce a new affiliation with a health plan; and
• Co-sponsor events such as health fairs and advertise indirectly with a health plan, via television, radio, posters, flyers and print advertisements.

Providers are prohibited from:

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

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

Overview
WellCare may, by written contract, delegate certain functions under WellCare’s contracts with CMS and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales & marketing, utilization management, quality management, case management, disease management, claims processing, credentialing, network management, Provider appeals, and customer service. WellCare may delegate all or a portion of these activities to another entity (a Delegated Entity).

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

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

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

WellCare monitors compliance through the delegation oversight process and the Delegation Oversight Committee by:
- Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs
- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity’s ability to perform the delegated function
- Providing guidance on written agreement standards with delegated entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity
- Conducting ongoing monitoring activities to evaluate an entity’s performance and compliance with regulatory and accreditation requirements
• Conducting annual audits to verify the entity’s performance and processes support sustained compliance with regulatory requirements and accreditation standards
• The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity’s performance is substandard or terms of the agreement are violated
• Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements of WellCare’s Medicare and Medicaid program
• Track and trend internal compliance with oversight standards, entity performance, and outcomes
Section 10: Behavioral Health

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

Behavioral Health Program
Some behavioral health services may require Prior Authorization, including all services provided by non-participating Providers. WellCare uses Milliman Clinical Guidelines (MCG) for all behavioral health services (effective 3/4/2019), and American Society for Addiction Medicine (ASAM) criteria, for substance use disorder, among other clinical criteria used by WellCare. These criteria are well known and nationally accepted guidelines for assessing level of care criteria for behavioral health.

For complete information regarding benefits, exclusions and authorization requirements, or to contact WellCare’s Provider Services for a referral to a behavioral health Provider, refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

Responsibilities of Behavioral Health Providers
WellCare monitors Providers utilizing the standards below 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: Emergency</td>
<td>Right away (prior authorization is not required for emergency services)</td>
</tr>
<tr>
<td>Non-life Threatening Emergency</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Behavioral health Provider: Crisis Stabilization</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Behavioral health Provider: urgent care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Behavioral health Provider: regular appointments</td>
<td>Less than 10 business days</td>
</tr>
<tr>
<td>Behavioral health Provider: post inpatient psychiatric discharge; first follow-up appointment</td>
<td>Within 7 days of discharge</td>
</tr>
</tbody>
</table>
All Members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place, and name of the Provider to be seen. The outpatient treatment must occur within seven days from the date of discharge.

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

Behavioral health Providers are expected to assist Members in accessing emergent, urgent, and routine behavioral services as expeditiously as the Member’s condition requires.

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

Behavioral Health Providers are required to use the ICD-10 or current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) multi-axial classification when assessing the Members for Behavioral Health services, and document the diagnosis and assessment/outcome information in the Member’s medical record.

**Alcohol and Other Drug Abuse Treatment Services Authorized or Provided by State Agencies (DAODAS Services)**

All Members requiring level 1 (discrete) or level 2 (intensive outpatient program) services through DAODAS and its subcontracted authorities or through private providers, will require the rendering Provider to fax a prior authorization (PA) request along with the Individual Plan of Care (IPOC) and patient assessment to WellCare. Should a prior authorization be needed in support of a continuation of services, the rendering Provider must fax a continued stay authorization form in addition to an updated IPOC when appropriate.

Members requiring residential detoxification, partial hospitalization and/or day treatment through DAODAS and its subcontracted authorities or through private providers, will require their rendering Provider to call WellCare to request a prior authorization for both initial and continuation of services. Service level agreements are in place with WellCare to ensure a timely response from Provider requests for prior authorization.

WellCare must respond within five business days to initial prior authorization requests for level 1 and level 2 services.

WellCare must respond within 14 calendar days to prior authorization requests for a continuation of existing services for level 1 and level 2 services.

WellCare will respond to prior authorization requests for detox, residential, partial hospitalization and/or day treatment within 24 hours, or no later than the close of business on the following business day.
Procedure for DAODAS/Private Substance Abuse Providers and RBHS/ASD Providers

Procedure for alcohol and other drug abuse treatment services authorized or provided by state agencies (DAODAS services)/private providers and Rehabilitative Behavioral Health Services (RBHS services)/Autism Spectrum Disorder services (ASD services):

- The Provider contacts WellCare to request prior authorization for DAODAS/substance abuse services.
- The Provider contacts WellCare to request prior authorization for some RBHS services/ASD services.
- The request is routed to a South Carolina queue within Health Services.
- The licensed behavioral health professional will review services according to the appropriate time frame as outlined in the grid below.

In order to ensure compliance, WellCare will use the response time standard that applies for the behavioral health service request as detailed in the table below:

<table>
<thead>
<tr>
<th>Description</th>
<th>Prior/Initial Authorization Turn-around Time</th>
<th>Concurrent/Ongoing Authorization Turn-around Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Detox</td>
<td>72 hours</td>
<td>1 calendar day</td>
</tr>
<tr>
<td>BH Inpatient</td>
<td>72 hours</td>
<td>1 calendar day</td>
</tr>
<tr>
<td>BH Partial Hospitalization or Day Treatment Program</td>
<td>1 business day</td>
<td>1 business day</td>
</tr>
<tr>
<td>BH Psychiatric Residential Treatment Facility (PRTF)</td>
<td>7 calendar days</td>
<td>7 calendar days</td>
</tr>
<tr>
<td>Substance Abuse Residential</td>
<td>1 business day</td>
<td>1 business day</td>
</tr>
<tr>
<td>BH Psych Testing</td>
<td>14 calendar days</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>BH Intensive Outpatient Treatment</td>
<td>5 business days</td>
<td>5 business days</td>
</tr>
<tr>
<td>Substance Abuse Rehab</td>
<td>1 business day</td>
<td>1 business day</td>
</tr>
<tr>
<td>BH Routine Outpatient DAODAS Providers</td>
<td>14 calendar days</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Physician Charges for ECT</td>
<td>3 calendar days</td>
<td>1 calendar day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WellCare of South Carolina, Inc.
Medicaid Provider Manual
Provider Services: 1-888-588-9842

Effective: August 12, 2019
Rehabilitative Behavioral Health Services

Rehabilitative Behavioral Health Services are available to all Medicaid beneficiaries diagnosed with mental health and/or substance use disorder(s), as defined by the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD) who meet medical necessity criteria. Services are provided to, or directed exclusively, toward the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary’s ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.

Eligible beneficiaries may receive Rehabilitative Behavioral Health Services from a variety of qualified Medicaid Providers. Public agencies that contract with SCDHHS as qualified service Providers may render these services directly to an eligible beneficiary.

The following rehabilitative services will be rendered in accordance with the RBHS implementation as of 7/1/2016:

- Behavioral Health Screening
- Diagnostic Assessment Services
- Psychological and Evaluation and Testing
- CALOCUS Assessment
- Individual Psychotherapy
- Group Psychotherapy
- Multiple Family Group Psychotherapy
- Family Psychotherapy
- Service Plan Development
- Crisis Management
- Medication Management
- Psychosocial Rehabilitation Services
- Behavior Modification
- Family Support
- Peer Support Services (DMH and DAODAS Provider only)
- Therapeutic Child Care
- Community Integration Services
- Substance Abuse Treatment Services

Autism Spectrum Disorder Services

Autism Spectrum Disorder Services are available to all Medicaid beneficiaries when there is a primary psychiatric diagnosis of Autism Spectrum Disorder from the current
edition of the DSM and/or ICD, and services are determined medically necessary. Beneficiaries who meet these criteria must be 0 to 21 years of age. Autism Spectrum Disorder services are utilized to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the individual. Eligible beneficiaries may receive Autism Spectrum Disorder Services from a variety of qualified Medicaid Providers (i.e., licensed independent practitioners, Doctoral and Masters level certified Behavior Analysts (BCBA-D and BCBA), certified Behavior Analyst Assistants (BCaBA), and Registered Behavior Technicians (RBT)).

The following autism spectrum disorder services are rendered in accordance with the ASD implementation:

- Behavior Identification Assessment
- Adaptive Behavior Treatment by Protocol
- Adaptive Behavior Treatment with Protocol Modification
- Family Adaptive Behavior Treatment Guidance
- Non-ABA Treatment Services

**Psychiatric Residential Treatment Facility Services (PRTF)**

PRTF services are available to all Medicaid beneficiaries when services are determined to be medically necessary. Beneficiaries who meet the criteria must be 0 to 21 years of age. Psychiatric Residential Treatment Facilities are facilities, other than a hospital, that provides psychiatric services to children younger than age 21 in a 24-hour treatment setting. PRTFs provide high intensity psychiatric services to children who do not need acute inpatient psychiatric care, but need a highly structured treatment environment. PRTF’s provide a 24 hours, 7 days per week level of care to mental health beneficiaries.

**Opioid Program**

WellCare has created a new comprehensive Opioid Program, a national Medicaid and Medicare program for Members who overuse opioid medications and/or appear to be at risk of doing so.

The goals of the program are to:
- Promote the appropriate use of healthcare resources; and
- Reduce the risk of opioid misuse, dependence and ultimately overdose, improving our Members’ health outcomes.

Interventions include:
- Care Management for Members who have been locked in to one pharmacy
- Care management for Members with low back pain and a high number of opioid prescriptions; and
- Care management for Members who have been proactively identified as being at high risk of misuse of opioids and
• Care management for Members who over utilize the emergency room for primary care services.

WellCare invites our Providers to use this program to minimize inappropriate opioid prescribing and to refer to appropriate treatment as necessary. To learn more about WellCare’s Opioid Program, visit the Provider manual at www.wellcare.com.

Opioid Treatment Programs (OTPs)
As of July 1, 2019, OTP services are available to all Medicaid beneficiaries. These services are intended to provide medically necessary treatment to eligible Medicaid beneficiaries with a diagnosis of opioid use disorder (OUD).

Eligible beneficiaries may receive OTP services from providers that have certification with DEA, SAMHSA, DHEC and the SC Board of Pharmacy. OTP providers must also have accredited programs by CARF, JCAHO or another SAMHSA-approved OTP-accrediting body.

All OTP services should be billed on the CMS 1500 claim form. OTP services that can be billed include:
• Medication-Assisted Treatment – Initial/Annual Assessment
• Buprenorphine Maintenance Treatment – Billed as a weekly bundle
  OR
• Methadone Maintenance Treatment – Billed as a weekly bundle

Continuity and Coordination of Care between Medical Care and Behavioral Healthcare
PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, Behavioral Health Providers may provide physical healthcare services if and when they are licensed to do so within the scope of their practice. Behavioral Health Providers are required to use the ICD-10 or current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) when assessing the Member for behavioral health services and document the diagnosis and assessment/outcome information in the Member’s medical record.

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

WellCare strongly encourages open communication between PCPs and behavioral health Providers to help guide and ensure the delivery of safe, appropriate, efficient and
quality clinical healthcare. If a Member’s medical or behavioral condition changes, WellCare expects that both PCPs and behavioral health Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers.

Effective Continuity of Care of care is dependent upon clear and timely communication and allows for better decision making regarding treatment interventions, decreases the potential for fragmentation of treatment and improves Member health outcomes.

To maintain continuity of care, patient safety and Member well-being, communication between behavioral healthcare Providers and medical care Providers is critical, especially for Members with comorbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and thus affect Member outcomes.
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
- Prior Authorization Process
- Provider Education Program (PEP)

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

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

Prescription Drug coverage will be provided by WellCare according to the Member’s needs. The pharmacy benefit provided by WellCare must comply with the coverage and benefit guidelines set forth in section 1927(k)(2) of the Social Security Act.

To contact WellCare’s Pharmacy Services, please refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/South-Carolina/providers/Medicaid.

Preferred Drug List (PDL)
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 the drug’s efficacy, safety, side effects, pharmacokinetics, clinical literature and cost effectiveness profile. The medications on the PDL are organized by the following: 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/South-Carolina/providers/Medicaid/Pharmacy. Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to Providers as follows:
• Quarterly updates in Provider newsletters;
• Website updates, including the P&T PDL change notices; and/or
• Pharmacy and Provider communication (letters, faxes, etc.) that detail any major changes to a particular therapy or therapeutic class.

Negative PDL changes will be published on WellCare’s website at least 30 days before implementation.

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 at www.wellcare.com/South-Carolina/providers/Medicaid. For more information on requesting exceptions, refer to the Coverage Determination Review Process below.

Coverage Limitations

The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

• Agents used for anorexia, weight gain or weight loss
• Agents used to promote fertility
• Agents used for cosmetic purposes or hair growth
• Drugs for the treatment of erectile dysfunction
• DESI drugs or drugs that may have been determined to be identical, similar or related
• Investigational or experimental drugs
• Agents prescribed for any indication that is not medically accepted

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

Effective for dates of service on or after July 1, 2015, medications for the treatment of Hepatitis C Virus (HCV) will be carved out of the South Carolina Medicaid Managed Care Organization pharmacy benefit. For dates of service on or after July 1, 2015, these medications will be provided to Managed Care Organization beneficiaries through the fee-for-service (FFS) pharmacy program.

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

For a complete listing, please refer to the PDL on our website at www.wellcare.com/South-Carolina/providers/Medicaid/Pharmacy.
**Member Co-payments**  
Members are responsible for paying $3.40 for all drugs listed on the PDL; however children younger than 19 years of age and pregnant women have no co-payments.

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

Generic medications must be dispensed by the pharmacist when available as the therapeutic equivalent to a brand name drug. To request an exception to the mandatory generic policy, a *Universal Prior Authorization Medications Form* should be completed and submitted. Clinical justification as to why the generic alternative is not appropriate for the Member should be included with the *Universal Prior Authorization Medications Form*.

For more information on the prior authorization review processed, including how to access the *Universal Prior Authorization Medications Form*, see the Prior Authorization process 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.

The PDL identified medications requiring Prior Authorization.

WellCare has the ability to require prior authorization on medications to ensure appropriate use and to encourage the use of preferred medications.

WellCare must process requests for prior authorization, with the determination communicated to the requestor, within 24 hours of the request.

**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. The PDL identifies medications requiring Step Therapy (ST).

**Quantity Limits**
Quantity limits ensure that pharmaceuticals are supplied in a quantity consistent with the FDA-approved dosing guidelines. Quantity limits also 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).

**Pharmacy Lock-In Program**
Members identified as overutilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple physicians, or frequently visiting the emergency room seeking pain medication, will be placed in Pharmacy Lock-In status for a minimum of two years. While in Lock-In, the Member will be restricted to one prescriber and one pharmacy to obtain their medications. Claims submitted by other pharmacies will not be paid for the Member. Members identified will also be referred for Care Management. The Care management team will work with the Member to create an individualized Care Plan. Care managers provide monitoring, education, communication and collaboration, and can assist with access to alternative treatments to improve a Member’s health. For questions or concerns regarding the lock-in program, Members or Providers may call 1-888-588-9842 Monday–Friday, 8 a.m. to 6 p.m. TTY/TDD users may call 711.

In order for the Department to impose these restrictions per the CFR, the following conditions must be met:

- The Member must be given notice and opportunity for a fair hearing before imposing the restriction.
- The Member must have reasonable access (taking into account geographic location and reasonable travel) to Medicaid services of adequate quality.
- The restrictions do not apply to emergency services furnished to the Member.

**Medication Assistance Therapy (MAT) Minimum Coverage Criteria:**
Several FDA-approved medication assisted therapy medications are available without Prior Authorization on the preferred drug list (PDL). A list of the available medications is on the online PDL at [www.wellcare.com/en/South-Carolina/Providers/Medicaid/Pharmacy](http://www.wellcare.com/en/South-Carolina/Providers/Medicaid/Pharmacy).

**Prior Authorization Process**
The goal of the Prior Authorization Program is to ensure that medication regimens that are high-risk and have high potential for misuse or have narrow therapeutic indices are
used appropriately and according to Food and Drug Administration (FDA) approved indications. The Prior Authorization process is required for:

- Duplication of therapy;
- Prescriptions that exceed the Food and Drug Administration (FDA) daily or monthly quantity limit;
- 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 *Universal Medications PA Form*, supplying pertinent Member medical history and information.

The *Universal Medications PA Form* is on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid/Forms](http://www.wellcare.com/South-Carolina/providers/Medicaid/Forms). Additional PA forms are available based on the type of request or medication requested.

To submit a request, orally or in writing, refer to the contact information listed in the *Quick Reference Guide* on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid](http://www.wellcare.com/South-Carolina/providers/Medicaid). Upon receipt of the form, a decision is completed within 24 hours. WellCare has a Pharmacy Override Policy, which allows no less than a 72-hour emergency supply of all prescription drugs to be supplied to the Member. This emergency supply requires no prior authorization or call to WellCare. In such instances, pharmacy Providers must enter the prior authorization number 00000000120. If authorization cannot be approved or denied, and the drug is Medically Necessary, up to a 72-hour emergency supply of the non-preferred drug can be supplied to the Member if the pharmacy calls WellCare.

**Medication Appeals**

To submit a request to appeal a prior authorization decision, orally or in writing, refer to the contact information listed in the *Quick Reference Guide* on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid](http://www.wellcare.com/South-Carolina/providers/Medicaid).

Once the appeal of the prior authorization decision has been properly submitted and obtained by WellCare, the request will follow the appeals process described in *Section 7: Appeals and Grievances* in this Manual.

**Pharmacy Management – Provider Education Program**

The Provider Education Program (PEP) is designed to provide physicians 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 Customer Service for information on how to access pharmacy services. Contact information is located on the *Quick Reference Guide* on WellCare’s website at [www.wellcare.com/South-Carolina/providers/Medicaid](http://www.wellcare.com/South-Carolina/providers/Medicaid).

**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 is an expert in the special handling, storage and administration that injectables, infusibles, orals, and other medications require. This team knows the insurance process and the Member’s plan benefits. This means less chance of delays in a Member receiving their needed medication(s). Prescription orders generally ship directly to the Member’s home, Provider’s office, or alternative address provided by the Member, within 24 to 48 hours after contacting an Exactus Pharmacy Solutions representative. The actual ship date depends on whether or not Provider discussion is needed about the prescription.

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

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

“Abuse” means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

ACIP – Centers for Disease Control Advisory Committee on Immunization Practices.

Administrative Days – Inpatient hospital days associated with nursing home level patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient stay.

Advanced Directives – A written instruction, such as a living will or durable power of attorney for healthcare, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of healthcare when the individual is incapacitated. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.100]

Adverse Benefit Determination – The denial or limited authorization of a requested service, including the type or level of service;

- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the State;
- The failure of WellCare to process grievances, appeals or expedited appeals within the time frames provided in this Contract.

“Appeal” is a request for review of an Action as defined by 438.400 or a decision by or on behalf of WellCare related to the Covered Services or services provided.

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

Authorized Representative – An Authorized Representative is an individual granted authority to act via SC DHHS Form 1282 ME, Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications Reviews and
Appeals, who is acting for the Applicant/Beneficiary with the Applicant/Beneficiaries’ knowledge and consent and who has knowledge of his circumstances

**Behavioral Health** – A state of health that encompasses mental, emotional, cognitive, social, behavioral stability including freedom from substance use disorders.

**Behavioral Health Provider** – Individuals and/or entities that provide Behavioral Health Services.

**Behavioral Health Services** – The blending of mental health disorders and/or substance use disorders prevention in treatment for providing comprehensive services.

**Beneficiary** – An applicant approved for and receiving Medicaid benefits.

“**Benefit Plan**” is a health benefit policy or other health benefit 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** – Monday through Friday from 9 A.M. to 5 P.M., excluding State holidays

**Calendar Days** – All seven days of the week (i.e., Monday, Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday).

**Care Management** – Care management is a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aims of improving patients’ functional health status, enhancing coordination of care, eliminating duplication of services and reducing the need for expensive medical services (NCQA).

“**Centers for Medicare & Medicaid Services (CMS)**” is the U.S. federal agency that administers Medicare, Medicaid and the Children’s Health Insurance Program.


- The CFR is divided into 50 titles representing broad areas subject to Federal regulation
- Each Title is divided into chapters that are assigned to agencies issuing regulations pertaining to that broad subject area. Each chapter is divided into parts and each part is then divided into sections – the basic unit of the CFR.
- The purpose of the CFR is to present the official and complete text of agency regulations in one organized publication and to provide a comprehensive and convenient reference for all those who may need to know the text of general and permanent Federal regulations.
• The CFR is keyed to and kept up-to-date by the daily Federal Register. These two publications must be used together to determine the latest version of any given rule. When a Federal agency publishes a regulation in the Federal Register, that regulation usually is an amendment to the existing CFR in the form of a change, an addition, or a removal.

“Clean Claim” is a claim that can be processed without obtaining additional information from the Provider of the service or from a third party, and that is for Covered Services provided to a Member that (a) is received timely by WellCare, (b) has no defect, impropriety, or lack of substantiating documentation from the Member’s medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional WellCare specific requirements in the WellCare Companion Guide, including all then-current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for WellCare to (1) meet requirements of Laws and Program Requirements for reporting of Covered Services provided to Members, and (2) determine payer liability, and ensure timely processing and payment by WellCare. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

“CLIA” is 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.

Continuity of Care – Activities that ensure a continuum approach to treating and providing healthcare services to Medicaid Managed Care Members consistent with 42 CFR 438.208, the provisions outlined in South Carolina Managed Care Organization Medicaid Contract and the Managed Care Policy and Procedure Manual. This includes, but is not limited to:

• Ensuring appropriate referrals, monitoring, and follow-up to Providers within the network,

• Ensuring appropriate linkage and interaction with Providers outside the network.

• Processes for effective interactions between Medicaid Managed Care Members, in-network and out-of-network Providers and identification and resolution of problems if those interactions are not effective or do not occur.

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

“Covered Services” are items and services covered under a benefit plan.
Cultural Competency – A set of interpersonal skills that promote the delivery of services in a culturally competent manner to all Medicaid Managed Care Members—including those with limited English proficiency and diverse cultural and ethnic backgrounds—allowing for individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Medicaid Managed Care Members (as required by 42 CFR §438.206).

Department – For the purposes of this Contract, the term “Department” refers to the South Carolina Department of Health and Human Services (SCDHHS).

“EPSDT” is the Early and Periodic Screening, Diagnosis and Treatment program that provides Medically Necessary healthcare, 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 Medical Condition” means:

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

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

“Encounter Data” means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for clean claims.
**Family Planning Services** – Services that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

**Fraud Waste Abuse (FWA)** – FWA is the collective acronym for the terms fraud, waste and abuse.

“**Grievance**” is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, failure to respect the Member’s rights, or any aspect of the operations, activities, or behavior of WellCare.

“**Ineligible Person**” is an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) federal healthcare programs, as may be identified in the LEIE (List of Excluded Individuals/Entities maintained by the OIG), or (ii) federal procurement or non-procurement programs, as may be identified in the System for Award Management (SAM); (b) has been convicted of a criminal offense subject to OIG’s mandatory exclusion authority for Federal Healthcare 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.

**Medicaid** – The medical assistance program authorized by Title XIX of the Social Security Act.

“**Medically Necessary**” means that a service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to assist in the Member’s ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the Provider in accordance with WellCare’s guidelines, policies and/or procedures.

**Medical Record** – A single complete record kept at the site of the Member’s treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical healthcare services whether provided by WellCare, its Subcontractor, or any out-of-plan Providers.
At a minimum, for hospitals and mental health hospitals, the medical record must include:

1) Identification of the beneficiary.

2) Physician name.

3) Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 456.172 (mental hospitals) or 456.70 (hospitals).

4) Initial and subsequent continued stay review dates (described under 456.233 and 465.234 (for mental hospitals) and 456.128 and 456.133 (for hospitals).

5) Reasons and plan for continued stay if applicable.

6) Other supporting material the committee believes appropriate to include.

For non-mental hospitals only:

1) Date of operating room reservation.

2) Justification of emergency admission if applicable.

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

“Members with Special Healthcare Needs” are adult and child Members with special needs who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

National Committee for Quality Assurance (NCQA) – A private, 501(c)(3) non-profit organization founded in 1990, and dedicated to improving healthcare quality.

National Drug Code (NDC) – A unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identify the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

Non-Covered Services – Services not covered under the SC State Plan for Medical Assistance.

“Periodicity” is the frequency with which an individual may be screened or re-screened.
“Periodicity Schedule” means the schedule, which defines age-appropriate services and time frames for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program.

“PCP” or “Primary Care Provider” is the Provider who serves as the entry point into the healthcare system for the Member. The PCP is responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining continuity of care.

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

Qualified Medicaid Provider – Any provider actively enrolled with SCDHHS.

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

“Service” is healthcare, treatment, a procedure, supply, item or equipment.

“Service Location” is any location at which a Member may obtain any Covered Services from a Provider.

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

Abbreviations

AAP – American Academy of Pediatrics
ABD – Aged, Blind or Disabled
ACIP – Advisory Committee on Immunization Practices
ACS – American College of Surgeons
AHP – Allied Health Professionals
AIDS – Acquired Immune Deficiency Syndrome
AL – age limit
AMA – American Medical Association
AOR – Appointment of Representative
APRN – Advanced Practice Registered Nurse
ASC – ambulatory surgical centers
ASD – Autism Spectrum Disorder
CAD – coronary artery disease
CHF – congestive heart failure
CHIP – Children’s Health Insurance Plan
CLAS – Culturally and Linguistically Appropriate Services
CLIA – Clinical Laboratory Improvement Amendment
CM – care management
CMS – Centers for Medicare & Medicaid Services
CNM – Certified Nurse Midwife
COPD – chronic obstructive pulmonary disease
DAODAS – Department of Alcohol and Other Drug Abuse Services
DDE – direct data entry
DEA – Drug Enforcement Administration
DHHS – U.S. Department of Health and Human Services
DM – disease management
DME – durable medical equipment
DOC – Delegation Oversight Committee
DSM-IV – Diagnostic and Statistical Manual, Fourth Edition
EDI – Electronic Data Interchange
EOB – Explanation of Benefits
EOP – Explanation of Payment
EPSDT – Early and Periodic Screening, Diagnosis, and Treatment
ESRD – end stage renal disease
FDA – Food and Drug Administration
FQHC – Federally Qualified Health Center
FWA – fraud, waste, and abuse
HCPCS – Healthcare Common Procedure Coding System
HEDIS® – Healthcare Effectiveness Data and Information Set
HIPAA – Health Insurance Portability and Accountability Act of 1996
HIV – Human Immunodeficiency Virus
HMO – health maintenance organization
HRA – health risk assessment
ICD-10-CM – *International Classification of Diseases, 10th Revision, Clinical Modification*
ICD-10-PCS – *International Classification of Diseases, 10th Revision, Procedure Coding System*
IPAs – independent physician associations
IVR – interactive voice response system
JNC – Joint National Committee
SCCHIP – South Carolina Children’s Health Insurance Program
LTAC – long-term acute care
NCCI – National Correct Coding Initiative
NCQA® – National Committee for Quality Assurance
NDC – National Drug Codes
NIH – National Institutes of Health
NIP – Network Improvement Program
NPI – National Provider Identifier
NPP – Notice of Privacy Practices
OA – Osteopathic Assistant
OB – obstetrical/obstetrician
OB/GYN – obstetrician/gynecologist
OIG – Office of Inspector General
OT – occupational therapy
OTC – over-the-counter
P&T Committee – Pharmacy and Therapeutics Committee
PA – Physician Assistant
PCC – primary care clinic
PCP – primary care Provider
PDL – preferred drug list
PHI – protected health information
PPC – Provider preventable condition
Provider ID – Provider identification
PRTF - Psychiatric Residential Treatment Facility
PT – physical therapy
QIO – Quality Improvement Organization
QI Program – Quality Improvement Program
QL – quantity limit
RBHS – Rehabilitative Behavioral Health Services
RHC – rural health clinic
SCDHHS – South Carolina Department of Health and Human Services
SCM – short-term care management
SFTP – secure file transfer protocols
SIE – site inspection evaluation
SNF – skilled nursing facility
SNIP – Strategic National Implementation Process
SSI – Supplemental Security Income
SSN – Social Security number
ST – speech therapy
ST – step therapy
TB – tuberculosis
TIN/Tax ID – tax identification number
TTY/TDD – Telephone Typewriter/Telecommunications Device for the Deaf
UM – utilization management
VFC – Vaccines for Children
WEDI – Workgroup for Electronic Data Interchange
WIC – Women, Infants and Children Program
Section 13: WellCare Resources

WellCare of South Carolina Homepage
www.wellcare.com/south-carolina

Provider Homepage
www.wellcare.com/South-Carolina/providers

Provider Manual and Other Provider Resources
www.wellcare.com/South-Carolina/providers/Medicaid

Forms and Documents
www.wellcare.com/South-Carolina/providers/Medicaid/Forms

Quick Reference Guide
www.wellcare.com/South-Carolina/providers/Medicaid

Clinical Practice Guidelines
www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CPGs

Clinical Coverage Guidelines
www.wellcare.com/South-Carolina/providers/Clinical-Guidelines/CCGs

Job Aids and Resource Guides
www.wellcare.com/South-Carolina/providers/Medicaid

Claims Updates
www.wellcare.com/South-Carolina/providers/Medicaid/Claims

Pharmacy
www.wellcare.com/South-Carolina/providers/Medicaid/Pharmacy

Quality
www.wellcare.com/South-Carolina/providers/Medicaid/Quality

Behavioral Health
www.wellcare.com/South-Carolina/providers/Medicaid/Behavioral-Health
Quality care is a team effort. Thank you for playing a starring role!